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ABSTRACT

This is a collection of articles on the Rutland Center Model for Treating Emotionally Disturbed Children. The 2-year demonstration program, which became the prototype for a statewide network, was a cooperative effort to establish a system that could offer significant service to any seriously emotionally or behaviorally disturbed child, anywhere in Georgia. The document contains the following essays describing the center: "Rutland Center: A Community Psychoeducational Center for Emotionally Disturbed Children"; b) "The Rutland Center Evaluation System"; c) "Referral and Intake Procedures"; d) "Developmental Therapy"; e) "Implementing the Treatment Model"; f) "Field Services and Community Liaison"; g) "Services to Parents"; and h) "The Georgia Psychoeducational Center Network." Included are appendixes that contain questionnaires and information and evaluation forms. (Related document is SP 007 580.) (JA)

ED 087703

THE RUTLAND CENTER MODEL
FOR TREATING
EMOTIONALLY DISTURBED
CHILDREN

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PROTOTYPE FOR THE

GEORGIA PSYCHOEDUCATIONAL CENTER NETWORK

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1972

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FOREWORD

The design for The Georgia Psychoeducational Center Network grew from the experiences of parents, teachers, clinicians, legislators and a caring community seeking ways to help seriously disturbed children. Distraught, concerned, and frustrated with the paucity of services and the overwhelming need for help, these concerned people joined in a cooperative effort to establish a system which could offer significant service to any seriously emotionally or behaviorally disturbed child, anywhere in Georgia.

A two year demonstration project at the Rutland Center became the prototype for a statewide network, demonstrating and evaluating several basic convictions about ways to most effectively reduce severe emotional and behavioral problems of young children. These convictions are:

1. Keep these children out of a residential institution by offering comprehensive child services in their communities.
2. Keep their families actively involved in supportive ways.
3. Keep them in regular school, with teachers actively involved, while special help is given.
4. Bring child specialists from numerous professions together in a collective effort on behalf of these children.

The first step has been realized. In 1972 the Georgia Board of Education and Georgia Board of Health approved a network design based upon the success of the demonstration effort at the Rutland Center. The 1972 Georgia General Assembly responded to the design with support and appropriations. The result was establishment of the Georgia Psychoeducational Center Network, July 1, 1972, providing for operation of fourteen psychoeducational centers before the end of the fiscal year, serving approximately 2,595 children and their families.

A second phase is in active planning, and by 1976 the people of Georgia can see that help for every seriously troubled child in Georgia will become a reality.

July 1, 1972

Concerning the Authors

Amy Lee Fendley, M.Ed., received her Master of Education degree from the University of Georgia in the education of emotionally disturbed children. As a graduate student and later as a University instructor, she worked with Dr. Mary M. Wood to establish the first cooperative, community linkage between the University's Special Education Clinic for Emotionally Disturbed Children and the local public health department's Psychiatric Clinic for Children. This cooperative effort, begun in 1966, became the first step towards the Rutland Center Model.

Carl J. Huberty, Ph.D., received his doctoral training in education research from the University of Iowa and presently is a member of the University of Georgia faculty in the Department of Educational Psychology. He has served as consultant in evaluation to the Rutland Center since its inception and is a major author of the evaluation system.

Bonnie Lee Mailey, Ed.S., obtained the Educational Specialist degree from the University of Georgia in the field of education of emotionally disturbed children. In addition to a number of years experience teaching mentally retarded and emotionally disturbed children, she has held a faculty appointment at the

University and has served as clinic supervisor, intern supervisor, and as Coordinator of School Liaison and Field Services since the Rutland Center was established.

Herbert D. Nash, M.A., is the state director of Special Education. In this position he serves also as the administrator of the Georgia Psychoeducational Center Network. Mr. Nash led the statewide effort to provide special education for all of Georgia's exceptional children and first envisioned the Network as an effective service delivery system to reach these children.

William W. Swan, Ed.D., received his doctoral training in educational research at the University of Georgia. He holds a faculty appointment at the University in the Division for Exceptional Children. During the period of Rutland Center's program development, Dr. Swan served as Coordinator of Evaluation and through his efforts the evaluation system is a highly successful, effective component within the model. Presently he has assumed responsibility for developing and implementing an evaluation system for the Georgia Psychoeducational Center Network in the position of Coordinator of Evaluation for the Technical Assistance Office.

Diane Weller, M.Ed., received the Master of Education degree in the education of emotionally disturbed children form the University of Georgia. She taught mentally retarded and emotionally disturbed children for seven years prior to her holding the present position as Coordinator of Psychoeducational Services at Rutland Center. In this capacity, she provides leadership for the implementation of Developmental Therapy at Rutland Center and has contributed significantly to methods, materials, procedures, and to evaluations.

Lesley Whitson, M.S.W., received the Master of Social Work degree from the University of Georgia. She trained at Rutland Centers as a social work intern. Subsequently as a research assistant she contributed considerably to the narrative descriptions of the intake process as it was developed for the Rutland Center model and for Developmental Therapy practices.

Mary Margaret Wood, Ed.D. received the doctorate from the University of Georgia and did posdoctoral training at Hilcrest Children's Center in Washington D.C. with Dr. Nicholas Long. On the faculty of the University of Georgia since 1963, Dr. Wood established the first teacher training program in Georgia for the preparation of teachers of emotionally disturbed children. For six years she directed the University's Special Education Clinic for Disturbed Children. She is the author of the Rutland Center model and Developmental Therapy.

Chapter One

RUTLAND CENTER
A COMMUNITY PSYCHOEDUCATIONAL CENTER FOR EMOTIONALLY DISTURBED CHILDREN*

Mary Margaret Wood
Amy Lee Fendley

Introduction

Rutland Center is a community-based facility in Athens, Georgia with three field centers in outlying areas, which combines professional mental health and special education personnel in a cooperative program of psychoeducational service to seriously emotionally disturbed or behaviorally disordered children. It is a joint project of the Northeast Georgia Community Mental Health Center, the Clarke County School System, the school systems of the ten counties in the mental health district, and community agencies. There are 53,405 children, birth to age 14, in this district.

The center assumed its present structure as the demonstration center for the Georgia Psychoeducational Center Network in the fall of 1970 when state level funding to the local school system made possible expansion of the original program at the Athens-Clarke County Mental Health Clinic for Children. Further support through a grant to the University of Georgia from the U. S. Office of Education, Bureau of Education for the Handicapped, under the Handicapped Children's Early Education Assistance Act, established a preschool service for infants and children, ages 0-6. Figure 1 presents an overview of these sources of support and lines of agency responsibility.

---

*Sections of this chapter appeared in Focus on Exceptional Children, vol. 3, no. 5, October, 1971, pp. 9-11.

Goals and Programs

Rutland Center's major goal is to decrease severe emotional and behavioral disorders of children through community-based comprehensive mental health service and a psychoeducational process known as Developmental Therapy.

To accomplish the major goal, the center operates through three basic components. These components along with brief descriptions of goals and functions are:

1. Psychoeducational Services to Children and Families

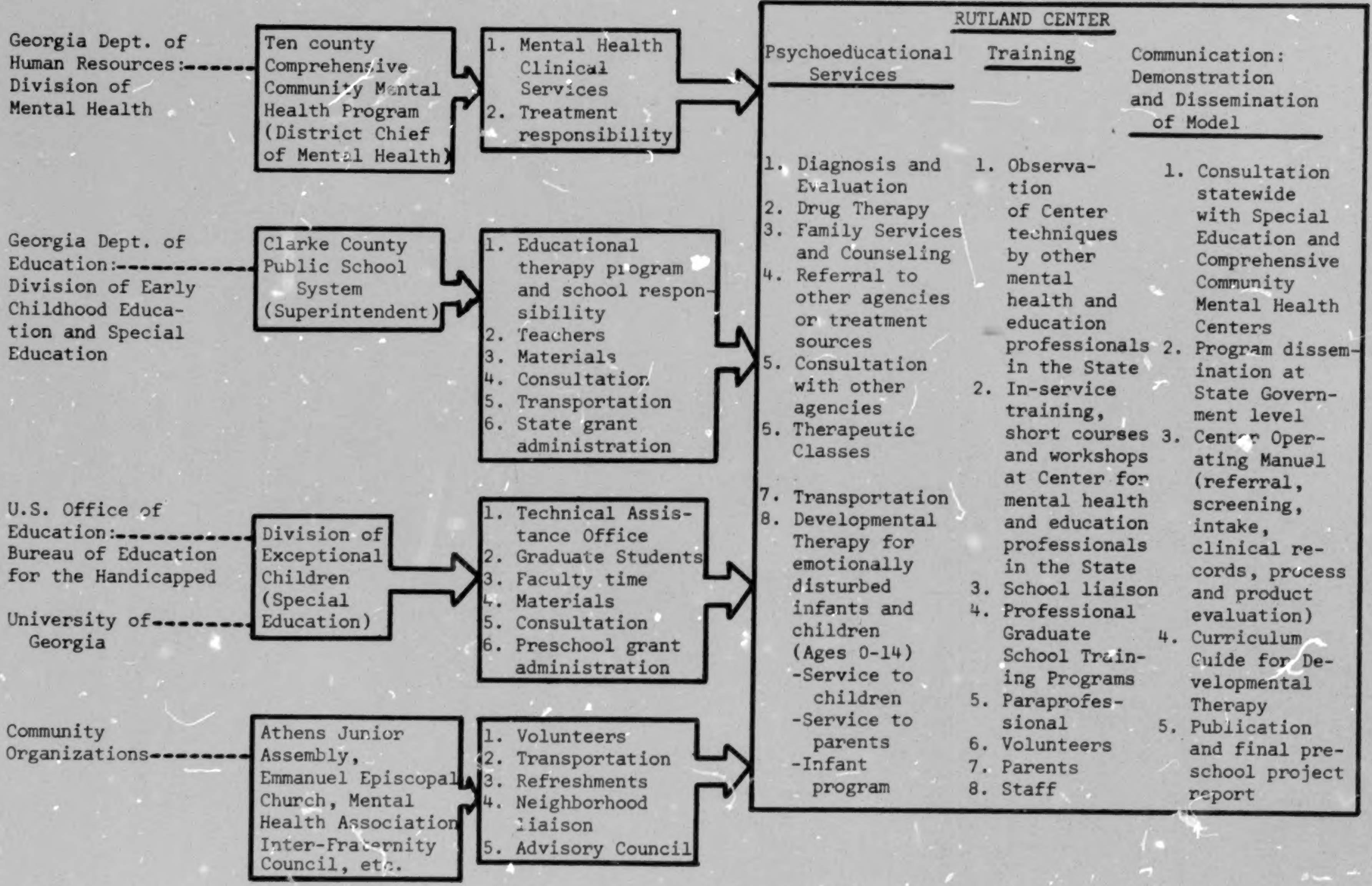
    Service to Children Goal:

    To increase the coping behavior of referred children in their home and school environment so that after a specified treatment period (estimated at staffing) these children will have achieved particular levels of Developmental Therapy (levels based on measurably stated objectives) in behavior, communication, socialization, and academics.

Figure 1

OVERVIEW OF RUTLAND CENTER

Sources of Support and Specific Programs


Georgia Dept. of Human Resources: Division of Mental Health
Ten county Comprehensive Community Mental Health Program (District Chief of Mental Health)
1. Mental Health Clinical Services
2. Treatment responsibility
Georgia Dept. of Education: Division of Early Childhood Education and Special Education
Clarke County Public School System (Superintendent)
1. Educational therapy program and school responsibility
2. Teachers
3. Materials
4. Consultation
5. Transportation
6. State grant administration
U.S. Office of Education: Bureau of Education for the Handicapped
University of Georgia
Division of Exceptional Children (Special Education)
1. Technical Assistance Office
2. Graduate Students
3. Faculty time
4. Materials
5. Consultation
6. Preschool grant administration
Community Organizations
Athens Junior Assembly, Emmanuel Episcopal Church, Mental Health Association Inter-Fraternity Council, etc.
1. Volunteers
2. Transportation
3. Refreshments
4. Neighborhood liaison
5. Advisory Council
RUTLAND CENTER
Psychoeducational Services
1. Diagnosis and Evaluation
2. Drug Therapy
3. Family Services and Counseling
4. Referral to other agencies or treatment sources
5. Consultation with other agencies
6. Therapeutic Classes
7. Transportation
8. Developmental Therapy for emotionally disturbed infants and children (Ages 0-14)
-Service to children
-Service to parents
-Infant program
Training
1. Observation of Center techniques by other mental health and education professionals in the State
2. In-service training, short courses and workshops at Center for mental health and education professionals in the State
3. School liaison
4. Professional Graduate School Training Programs
5. Paraprofessional
6. Volunteers
7. Parents
8. Staff
Communication: Demonstration and Dissemination of Model
1. Consultation statewide with Special Education and Comprehensive Community Mental Health Centers
2. Program dissemination at State Government level
3. Center Operating Manual (referral, screening, intake, clinical records, process and product evaluation)
4. Curriculum Guide for Developmental Therapy
5. Publication and final preschool project report

Service to Families Goal:

To provide information about the needs of referred children and assistance to families in meeting these needs.

The center provides psychoeducational services to approximately 267 severely emotionally disturbed children annually ages 2 to 14 years, from a ten county rural/urban area. They are referred to the center or to field centers in the rural areas primarily by the school systems of the counties served, but can also be referred by parents, physicians, psychiatrists, social workers, psychologists, or speech therapists. Each of the children attends class in his local school for part of the day, whenever possible, and attends class at Rutland Center or at a field center for two hours, four days a week.

Upon admission to the center, a child and his family are assigned to a psychoeducational team. Each of these teams consists of a trained special education teacher who has credentials to teach emotionally disturbed children, a social worker, and a trained paraprofessional or volunteer aide. The teacher and aide are responsible for the child's classroom program of Developmental Therapy; the social worker is familiar with the classroom program and interprets it to parents or other adults responsible for the child's care, helps the responsible adults to follow through in home, day care, or school with some of the techniques used at the center, and provides parent counseling or other social services as needed.

Each team is responsible for approximately fifteen children and their families. The teacher and aide operate two therapeutic classes daily, one in the morning and another in the afternoon. The social worker contacts each parent approximately once a week and also meets daily with the teacher and aide.

One day a week each center teacher works in the schools where Rutland Center children are enrolled, providing school followthrough, consultation, program development, crisis management, or other mental health activities as desired by the county school superintendent. This arrangement provides continuity between center services and those in the local community.

2. Technical Assistance

Goal: To enlist local support for present and new psychoeducational centers and stimulate development of new centers serving emotionally disturbed children throughout the state and to disseminate information concerning all phases of the project, model, and treatment method to interested professionals and community groups at local, state, and national levels.

Rutland Center serves as the prototype and as a resource for development of similar psychoeducational centers in other areas of the state. Through the University of Georgia, the center operates a Technical Assistance Office, staffed with Associates who have considerable expertise in all aspects of operating a psychoeducational center. Each Associate is responsible for program stimulation, in-service consultation on evaluation, design, training, and coordination of area mental health and special education resources for disturbed children in designated areas of the state. The Associates also assist developing areas in the preparation of a proposal for operational support of a center in that area. The Associates have access to the facilities, staff and materials at Rutland Center for in-service education, demonstration and program development. The State's long range goal is to develop a center in each mental health district, thereby putting psychoeducational services within access of every area of the state by 1976.*

3. Professional, Paraprofessional, and Volunteer Training

Goal: To provide information and training in Developmental Therapy techniques for the preparation of professional, paraprofessional, and volunteer personnel both within the

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*The Georgia Psychoeducational Center Network is described in Chapter Eight.

> center and outside, so that after varying time periods - dependent upon the trainee - the trainees will be able to work effectively in a selected aspect of the therapeutic process.

Rutland Center provides in-service education for mental health and school personnel throughout the state and a practicum site for University of Georgia graduate students. Short noncredit workshops and institutes for education and mental health professionals are conducted, focussing on psychoeducational services to severely disturbed children. Consultation about a specific child or situation is always available at the center for any education or mental health professional.

Graduate students from eight departments of the University of Georgia have done or are doing practicum work at the center. These students work with children in positions which gradually increase in responsibility and independence; however, they always have a faculty supervisor from the University and at all times work closely with center staff members.

The center has developed a program to train volunteers and paraprofessionals to use Developmental Therapy management techniques. A social worker concerned with neighborhood followthrough is responsible for identifying paraprofessional resources who can implement portions of the therapeutic process in the community. Paraprofessionals and volunteers also work in the center as members of the psychoeducational teams. The Coordinator of Psychoeducational Services is primarily responsible for their training.

The Therapeutic Curriculum

The therapeutic technique being used at Rutland Center is known as Developmental Therapy.* It is a group approach designed to be used in a variety of child treatment settings with special education teachers and mental health workers. Developmental Therapy is a treatment process which (1) by keeping a child in a normal school placement during the treatment process does not isolate the disturbed child from the mainstream of normal experiences, (2) by selected, simulated experiences in the therapeutic classroom uses normal sequential changes in development both to guide and to expedite the therapeutic process, and (3) through conceptualizing both clinical inference, teacher judgment, and behavioral measurement in the same model, has an evaluation system as part of the therapeutic process.

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*Chapter Four contains a detailed discussion of Developmental Therapy. The therapeutic curriculum guide will be available late in 1972. For information write to the Director, Rutland Center, 698 North Pope Street, Athens, Georgia, 30601.

The Developmental Therapy curriculum contains four curriculum areas as pedagogical translations designed to encompass the many possible problems of disturbed children. These curriculum areas and the messages to be conveyed to children in each of them are:

Behavior: "Appropriate behavior is important."

Communication: "It helps to talk about things."

Socialization: "The group is important."

Remediation or School Readiness: "This is school work you can handle."

Within each curriculum area in Developmental Therapy, maturational sequences and measurable objectives are outlined. The objectives are specific to each curriculum area, while the maturational sequences cut across all four areas. These sequences are:

Stage I: Responding to the Environment with Pleasure

Stage II: Responding to the Environment with Success

Stage III: Applying Individual Skills to Group Procedures

Stage IV: Valuing One's Group

Stage V: Applying Individual and Group Skills in New Situations

In general, materials used in the classrooms are designed to the individual needs of the children. They may be either teacher-made or purchased. Frequently they are self-correcting.

At the earlier stages, materials are as concrete as possible, with the use of symbolic representations increasing at later stages as the child is ready. A variety of toys which lend themselves to manipulative, imaginative, and creative play, and to group play, is available. Especially in Stages I and II, materials which are sensory-arousing and which command attention are used. Materials or equipment which encourage individual activity are avoided in favor of activities which stimulate group interaction.

Early Identification - The Infant Program

Rutland Center is concerned with constructing a system for early identification of infants and preschool children with developmental or emotional problems. Such a system is being developed through the Infant Program at the Public Health Department Well Baby Clinic and through Model Cities Infant Day Care Programs. Babies three months to two years in age are evaluated according to the Gesell Developmental Schedules. Their mothers are included in the evaluation procedure and, if it seems appropriate, are given suggestions as to how to provide stimulation to aide the infant's healthy development. All babies who attend the Well Baby Clinic at the Public Health Department or the Model Cities Day Care

Program are eligible for developmental evaluation in the Infant Program.

In addition, four therapeutic preschool classes, each with five to six seriously emotionally or behaviorally disturbed preschool children, under age six, are conducted at Rutland Center, using Developmental Therapy.

Staff

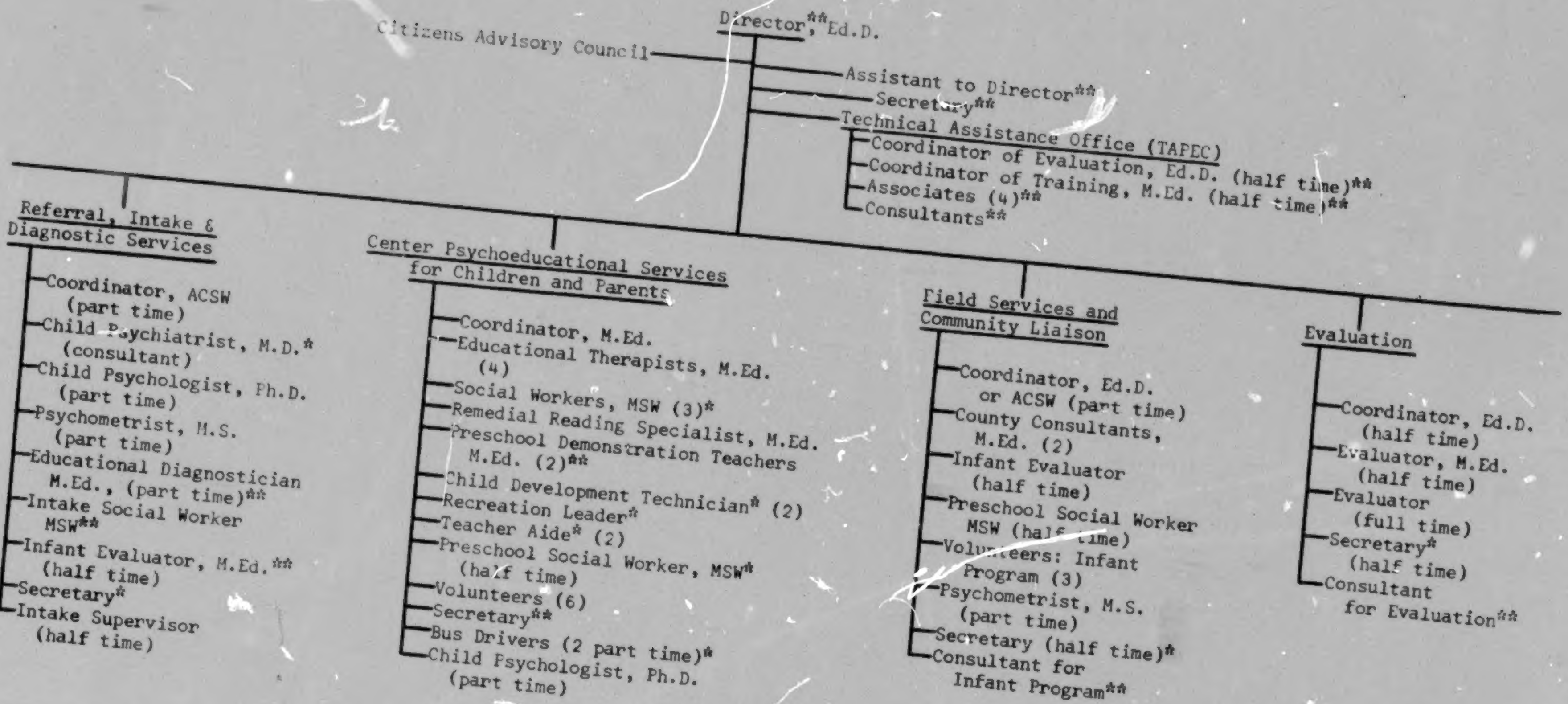
Figure 2 outlines the staff organization.

Several central staff members have administrative responsibilities for the treatment programs and are available to all parents and children in treatment. These central staff members include (1) a Director, with responsibility for the overall treatment program, administration, community contacts and support, the Technical Assistance Office, and public and professional dissemination of information concerning the facility; (2) a Coordinator of Psychoeducational Services, a master's level person with extensive training and experience in teaching emotionally disturbed children, who is administratively responsible for the daily psychoeducational services at the center, works closely with each treatment team and coordinates the work of all the teams in evaluating a child's needs, assigning him to a group, and planning a psychoeducational

Figure 2

RUTLAND CENTER STAFF ORGANIZATIONAL AND SERVICES CHART

July 1, 1972 - June 30, 1973


Director**, Ed.D.
Citizens Advisory Council
Assistant to Director**
Secretary**
Technical Assistance Office (TAPEC)
Coordinator of Evaluation, Ed.D. (half time)**
Coordinator of Training, M.Ed. (half time)**
Associates (4)**
Consultants**
Referral, Intake & Diagnostic Services
Coordinator, ACSW (part time)
Child Psychiatrist, M.D.* (consultant)
Child Psychologist, Ph.D. (part time)
Psychometrist, M.S. (part time)
Educational Diagnostician M.Ed., (part time)**
Intake Social Worker MSW**
Infant Evaluator, M.Ed.** (half time)
Secretary*
Intake Supervisor (half time)
Center Psychoeducational Services for Children and Parents
Coordinator, M.Ed.
Educational Therapists, M.Ed. (4)
Social Workers, MSW (3)*
Remedial Reading Specialist, M.Ed.
Preschool Demonstration Teachers M.Ed. (2)**
Child Development Technician* (2)
Recreation Leader*
Teacher Aide* (2)
Preschool Social Worker, MSW* (half time)
Volunteers (6)
Secretary**
Bus Drivers (2 part time)*
Child Psychologist, Ph.D. (part time)
Field Services and Community Liaison
Coordinator, Ed.D. or ACSW (part time)
County Consultants, M.Ed. (2)
Infant Evaluator (half time)
Preschool Social Worker MSW (half time)
Volunteers: Infant Program (3)
Psychometrist, M.S. (part time)
Secretary (half time)*
Consultant for Infant Program**
Evaluation
Coordinator, Ed.D. (half time)
Evaluator, M.Ed. (half time)
Evaluator (full time)
Secretary* (half time)
Consultant for Evaluation**

---

* Employed by Mental Health

** Employed by University of Georgia on special grants (TAPEC & Preschool) program for him; (3) a Coordinator of Liaison and Field Services, a senior social worker, who is administratively responsible for the treatment teams assigned to work in the rural field centers, assisting the treatment teams in making contact with each child's family, helping the family adjust as the child improves, teaching family members to use some of the management techniques used at the center, and providing group therapy for parents when appropriate; (4) a child psychologist who provides evaluation of children, consultation for the treatment teams in program planning and in Developmental Therapy; and who may work with parents individually or in groups; (5) a consultant child psychiatrist who evaluates children, monitors limited drug therapy, and acts as a consultant to the treatment teams using Developmental Therapy.

In addition to these central staff, there are four psychoeducational treatment teams each composed of an educational therapist (as "lead teacher"), social worker or child development technician (as "monitor"), and a teacher aide, volunteer, parent, graduate student, or paraprofessional (as "support teacher").* Also on the staff are a remedial reading specialist, three psychoeducational teams for the rural field centers, an infant evaluator and two program evaluators who implement the Developmental Therapy evaluation system, gathering data for quantifying the changes seen in children who attend Rutland Center and documenting the process of change. Several University of Georgia faculty members serve as program consultants and professional advisors.

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*The responsibilities of each member of a treatment team are described in Chapter Five.

Because Rutland Center not only provides treatment but also is a training and demonstration center there are several additional staff members in the Technical Assistance Office, including a Coordinator of Evaluation, a Coordinator of Training, four Associates, and curriculum and media specialists.

Field Centers

Three field centers ("outposts") jointly staffed by mental health staff and Rutland Center staff serve to (a) pool personnel resources; (b) avoid duplication of services; (c) provide a single referral process; (d) integrate services of the Rutland Center, the Mental Health Center and the school systems, and (e) bring direct services into the rural areas, thereby reducing need for transporting children long distances.

The three field centers are housed with each of the three Special Education Shared Services programs in county school districts.

The outposts are staffed by a full time educational therapist as county consultant from Rutland Center, a full or half time social worker, and a half time secretary paid for by the Mental Health Center. In addition, each outpost has the services of a school psychologist (or psychometrist) one full day per week from Rutland Center. All of Rutland Center clinical consultants are available for back-up on call. The Rutland Center Coordinator of Liaison and Field Services is administratively responsible for assuring that coordinated services are provided and for general administration of the program activities of Rutland Center staff. The Shared Services Director acts with supervisory responsibility for the activities of the staff and program at the field center.

The major activities of the field center are:

1. To help establish a coordinated referral procedure with rural school systems.
2. To establish community agency contacts for services.
3. To establish viable relationships with each elementary and preschool in the district.
4. To assist school personnel in helping teachers identify children needing special help.
5. To provide crisis services to particular children in the schools.
6. To provide observation, consultation, and program planning assistance to teachers.

7. To test children for educational and developmental diagnosis and prescriptive program planning

8. To screen and refer families and children to Rutland Center or Mental Health Center appropriately

9. To counsel parents regarding needs of children and provide assistance to obtain needed services

Community Support

Parental and community support is important to the success of any center of this sort. Rutland Center's Parent Auxiliary is increasingly active. The Auxiliary planned the dedication ceremony for the building, assembled a brochure describing Rutland Center, sponsored an annual art show of the children's work, raised funds with a highly successful rummage sale, and provided transportation for several children. A number of community organizations and private citizens have given additional aid or support to Rutland Center.

Each community organization with present or future working relationships with the center is represented on a Community Advisory Council. This group operates in two ways: (a) a small working committee provides a continuing advisory function to the project director in relation to state program development, and (b) all participating community persons and agencies functioning as a "committee of the whole", to serve on working committees as needed and to serve as active contact persons for on-going dissemination and communication to the community and to its service agencies.

The working committee includes a state senator; the executive committee from the Rutland Center Parents Auxiliary; Director of Special Education for the Georgia Department of Education; the Superintendent of Clarke County School System; the District Mental Health Chief; a representative from the Community Mental Health Branch of the Georgia Division of Mental Health, Georgia Department of Human Resources; the President of the Clarke County Mental Health Association; and the Director of the Model Cities Early Childhood Development Program.

Evaluation

The overall design for evaluating the Rutland Center effort is described in Chapter Two. The authors point out the essential importance of the evaluation system having a usefulness to the staff. Further, it is pointed out that to be useful, the evaluation system must be theoretically compatible with the treatment and service philosophy. The Rutland Center Evaluation System has proven to be highly successful on both points. Evaluation instruments and procedures, data collection, feedback, and program modification are integral aspects of all areas of effort.

Chapter Two presents the evaluation overview in four components: Service-to-Children, Service-to-Parents, Communication and Technical Assistance, and Administration. Each subsequent chapter contains explicit information about the evaluation instruments and procedures specifically used in that area of effort.

Evaluation of the administrative component of Rutland Center is concerned with the essential question: "How well is the center meeting its goals and objectives as specified for the Georgia Psychoeducational Center Network?" Evaluation of administrative activities includes collection of data on number served, amount of improvement shown, type of services rendered, costs, staff training, and forms of impact on the community. Several measures not specifically related to a particular area of effort have proven particularly useful in administrative decision making. These measures are: Staff Feedback Questionnaire, (Form 1), Training Session Evaluation Form, (Form 2), and Rutland Center Visitor Questionnaire, (Form 3). A brief description with directions and uses is contained, with a sample of each form, in the Appendix.

Benefits

The benefits of the Rutland Center model are seen as: (a) reducing the need for residential treatment for seriously disturbed children, (b) combining the resources of mental health fields and special education for more effective utilization of professional manpower, (c) combining educational and treatment responsibilities for more effective community programs of rehabilitation for these children and their families, (d) providing centrally located, comprehensive, professional resources for service and consultation to school systems and communities developing services for disturbed children, and (e) utilizing paraprofessional neighborhood people and parents to implement major portions of the therapeutic process.

Chapter Two

THE RUTLAND CENTER EVALUATION SYSTEM*

Carl J. Huberty
William W. Swan

Overview

The evaluation system at Rutland Center is considered an integral part of the overall project rather than an adjunct to it, and the evaluation personnel have taken, and are taking, an active role in the planning, monitoring, and appraising phases of all center operations. Because of this total involvement, the success of the evaluation system is dependent upon a well developed system of information exchange which enhances feedback and communication. The involvement of the evaluation team in the total project and its participation in the exchange of information are depicted in Figure 3. Note that the evaluation team is expected to provide evaluative services (in the form of planning, monitoring, and appraising) to each area of center effort: service-to-children, service-to-parents, communication and technical assistance, and administration.

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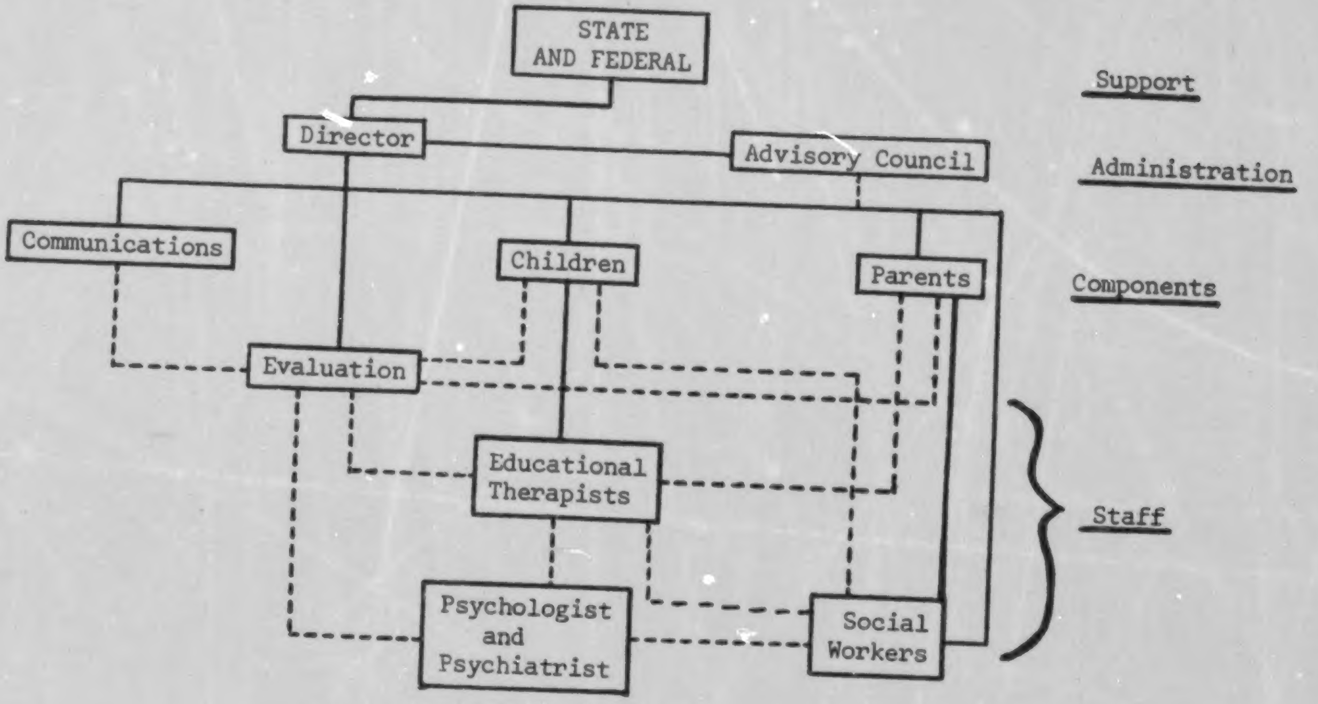
*Abstracted in part from "An Evaluation System for a Psychoeducational Treatment Program for Emotionally Disturbed Children" in Educational Technology, 1973, Huberty, C. J., Quirk, J. P., and Swan, W. W.

Figure 3

System of Information Exchange

(The solid lines indicate direct communication links that are based on the requirements of the program; the dash lines represent desirable communication links that depend upon intra-system rapport and cooperation.)


STATE AND FEDERAL
Director
Advisory Council
Communications
Children
Parents
Evaluation
Educational Therapists
Psychologist and Psychiatrist
Social Workers
Support
Administration
Components
Staff

The goals of the evaluation team are: 1) to assist in expressing questions to be answered and information to be obtained, 2) to collect the necessary information, and 3) to prepare the collected information in a form useful for decision makers for assessing decision alternatives. The information to be used in each component is in the form of data that provide descriptions and judgments of anything which feeds into the program (antecedents), happens during it (transactions), and results from it (outcomes), along with the contigencies among these (see Stake, 1967). The antecedents include such inputs as child and parent characteristics, referral data, environmental factors, and the psychoeducational curriculum and techniques. These inputs constitute a major contribution to the planning and development of the evaluation strategy (ies) to be subsequently employed. Involved in the transactions are the processes and interactions within and among learning activities, individuals, and materials. It is a function of the evaluation team to relate such data to the objectives and processes of each component. The outputs pertain to the individual client, to the home, and to the center. The concern with the output data is one of divising performance criteria, relating these data to the other two types of data, and supporting decisions regarding attainment of component objectives, need for treatment modification, need for reprogramming and recycling, and readiness for termination of treatment.

The various functions and roles of the evaluation team within the framework of the center are outlined in Figure 4. It is important to note that the three types of evaluation activities are neither independent nor mutually exclusive; they are not only compatible, but mutually supportive. As with the three kinds of data used for the evaluation effort, it is the interrelations of the three types of evaluation activities which produce the end product. Once the initial planning is completed, the model affords reassessing, modifying, and reprogramming the component strategies whenever desirable. Following decisions of reprogramming, the evaluative cycle repeats itself: planning, monitoring, and appraising. It is for this purpose that a well developed information exchange system within the center is needed. Such evaluative procedures make it possible to advantageously integrate data collection into the decision-making process.

Because of the theoretical limitations, and for practical and ethical reasons (especially with regard to the service-to-children component), the evaluation plans do not call for a comparative assessment of treatments or curricula. That is, the system does not include what is found in typical "research"

Figure 4

The Evaluation Process

Type of Activity	Function or Role	Method
Planning	Identify and assess needs and problems State treatment goals and objectives Identify and assess (alternative) strategies	Discussion with director, psychologist and evaluation team
	Implementation design Determine instrumentation for evaluation	Review of research; discussion involving director, psychologist, teachers and evaluation team
	Identify individual treatment objectives	Checklist, intake assessment, staff discussion
	Collect baseline data	Checklist, intake assessments, observation
Monitoring	Collect data pertaining to treatment effect (periodic assessment)	Behavioral observation form Objectives rating form Questionnaire and scales for parents Discussion with monitors
	Relate data to treatment objectives and process (feedback to staff)	Summary and analysis of collected data
	Assess proposal objectives Implementation evaluation	Inventory (completed by evaluator); questionnaires (completed by staff, parents)
Appraising	Devise criteria for concluding that treatment objectives have been attained	Inspection of collected data and discussion with staff
	Relate outcomes to objectives	Analysis of collected data
	Support decisions with regard to outcomes, recycling, reprogramming, termination	Discussion with director, psychologist, and therapist

or "experimental" settings; namely, random samples, constant "treatment", controlled variables, and comparison or control groups. Rather, the concern is with detailed descriptions and observations of individual and/or small classes. The position taken is similar to that of Cronbach (1963): the aim to compare one program with another should not dominate plans for evaluation; evaluation should be primarily concerned with the efforts of the program under study. Rutland Center effort is addressed to the question, "What changes can be observed in a certain kind of individual which can be attributed to an involvement in a certain kind of program intervention?" Some time ago, Luborsky (1959, p. 328) pointed out that "It has yet to be demonstrated that control groups in psychotherapy research have a more than very limited usefulness." The literature of the past decade has not produced much evidence to the contrary.

The Rutland Center evaluation methodology is not necessarily designed to yield universally valid information: the focus is on the Developmental Therapy treatment processes, an integral part of this psychoeducational model. The emphasis in the evaluation program may be likened to a current emphasis (controversy?) in education measurement namely, that of criterion-referenced measures. Rather than comparing the performance of individuals--children, parents--in the program with other individuals (norm-referencing), criteria are established for each individual; thus enabling the individual's progress to be assessed relative to himself. (This does not, of course, preclude the use of norm-referenced measures obtained from "standardized" tests to yield input data.) The criteria for attaining objectives are usually not determined until after the individual receiving services has entered the program and some assessment has been made. And the decision of whether or not an individual has attained a criterion established for him is based upon as much objective information as possible (test results, systematic observation, rating forms, etc.) supplemented by whatever clinical judgment is deemed pertinent. Such decisions are made following discussions involving an evaluator, a teacher, a psychologist, a monitor, and anyone else who may be familiar with the individual.

The success of such an evaluation methodology is highly dependent upon explicit statements of the goals and objectives of each of the program components. The inputs, transactions, and outputs must directly relate to the general objectives of each component as well as to specific objectives associated with the individual child or parent. The importance and role of the objectives are clearly reflected in the model (planning, monitoring, appraising) discussed previously. The emphasis is on (measurable) objectives as guidelines for action, and on meaningful observation and description in assessing an individual's progress or lack of it.

Service-to-Children

For an evaluation system to be employed in a treatment program it must not only be empirically sound but, more importantly, it must in the long run be useful to the program. To be useful, an evaluation system must be intimately tied to the philosophy and underlying theory upon which the treatment program is based. At Rutland Center the child treatment program is Developmental Therapy and evaluation of service-to-children is referenced to this method.

The general goal of the service-to-children component is: to provide developmentally referenced treatment experiences to referred children so as to enable them to better cope with their home and school environments. Measurable outcome objectives for the children involve decreasing the number and/or severity of behavioral problems by improving appropriate developmental skills. Having a problem behavior orientation and a developmental referent has made it possible to develop specific behavioral objectives for treatment planning and for measurement purposes.

The evaluation plan for the service-to-children component is viewed as consisting of five major phases which coincide with the flow of diagnostic and therapeutic procedures of the treatment program. The phases are intake, staffing, monitoring, termination, and tracking. Each phase is directly supported by data collected and summarized by the evaluation team (see Figure 5). The evaluation team assists in the delineation of the child's problems during intake and staffing, provides periodic feedback information necessary for maintaining and adjusting the treatment program, assists in specifying termination criteria, and obtains follow-up information after direct center treatment ends.

The evaluation and monitoring effort begins with the initial contact with parents and regular teacher and ends approximately one year after the child has been terminated from the treatment program. Throughout the diagnostic, staffing, and treatment phases of the program the evaluation system yields important informational feedback to the professional staff. All of the professional staff members participate in the development of procedures which provide the required data. These procedures are aimed at increasing the amount and usefulness of objective data employed in making clinical judgments.

More specific details regarding instrumentation and evaluation activities may be found in Figure 6 and in subsequent chapters.

Service-to-Parents

The goal of the service-to-parents component is to provide information to parents about the needs of the referred children and assistance to parents in meeting these needs; i.e., to provide

Figure 5

The Evaluation Plan for Services to Children

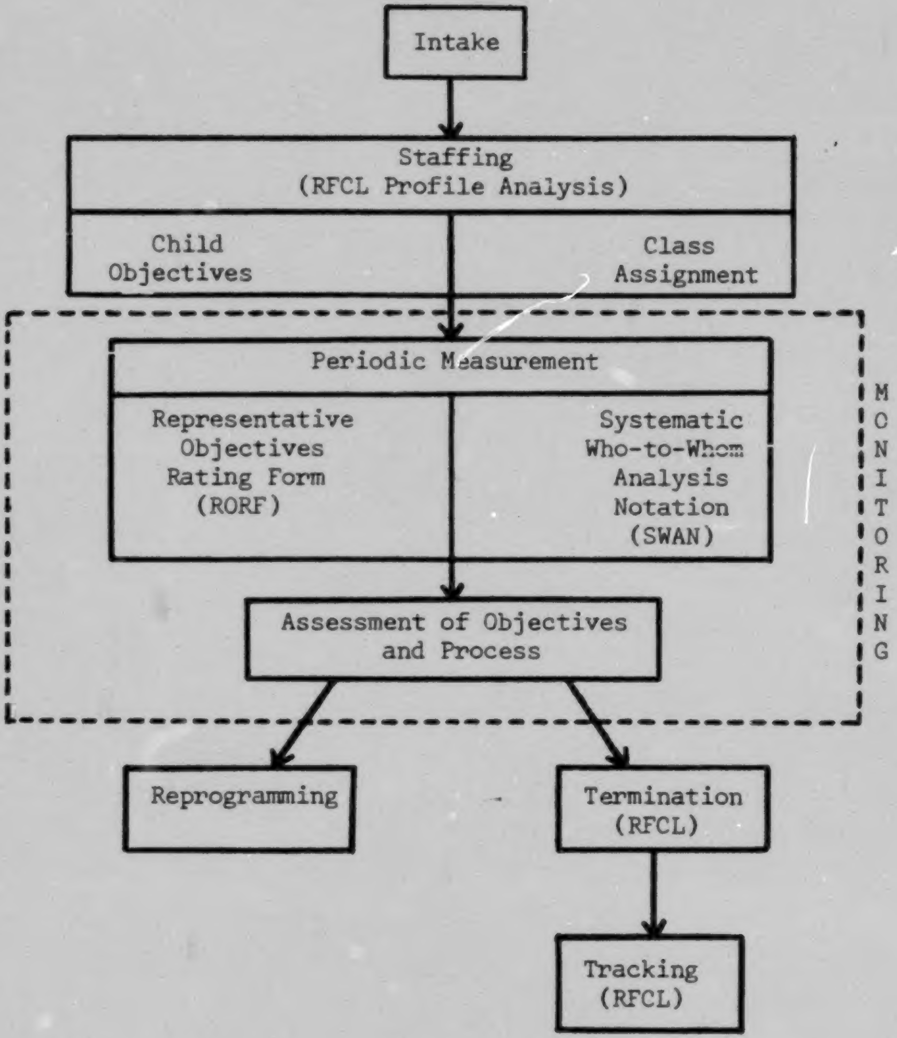

Intake
Staffing
(RFCL Profile Analysis)
Child Objectives
Class Assignment
Periodic Measurement
Representative Objectives Rating Form (RORF)
Systematic Who-to-Whom Analysis Notation (SWAN)
Assessment of Objectives and Process
MONITORING
Reprogramming
Termination (RFCL)
Tracking (RFCL)

FIGURE 6

OVERVIEW OF EVALUATION SCHEMA

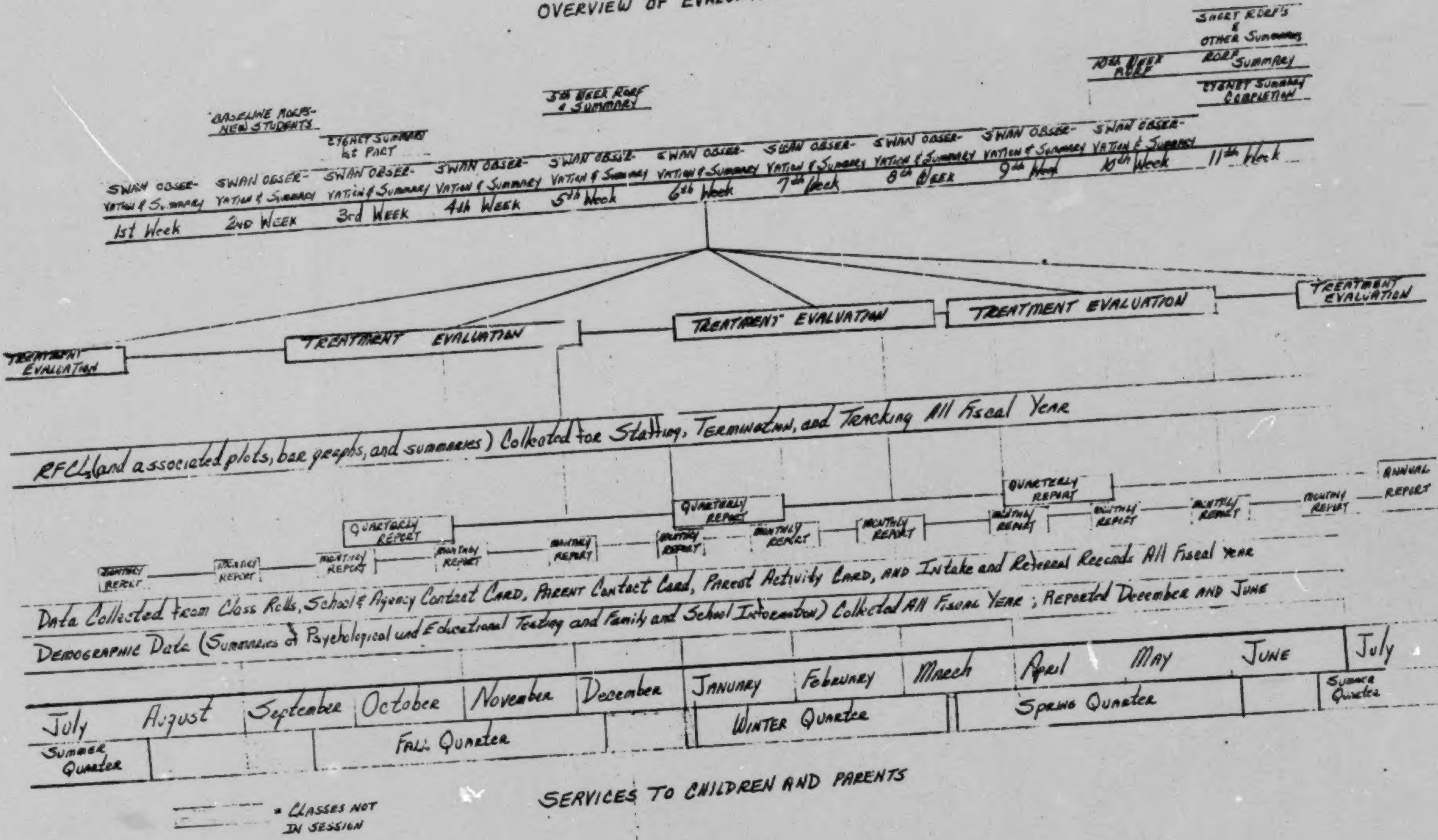
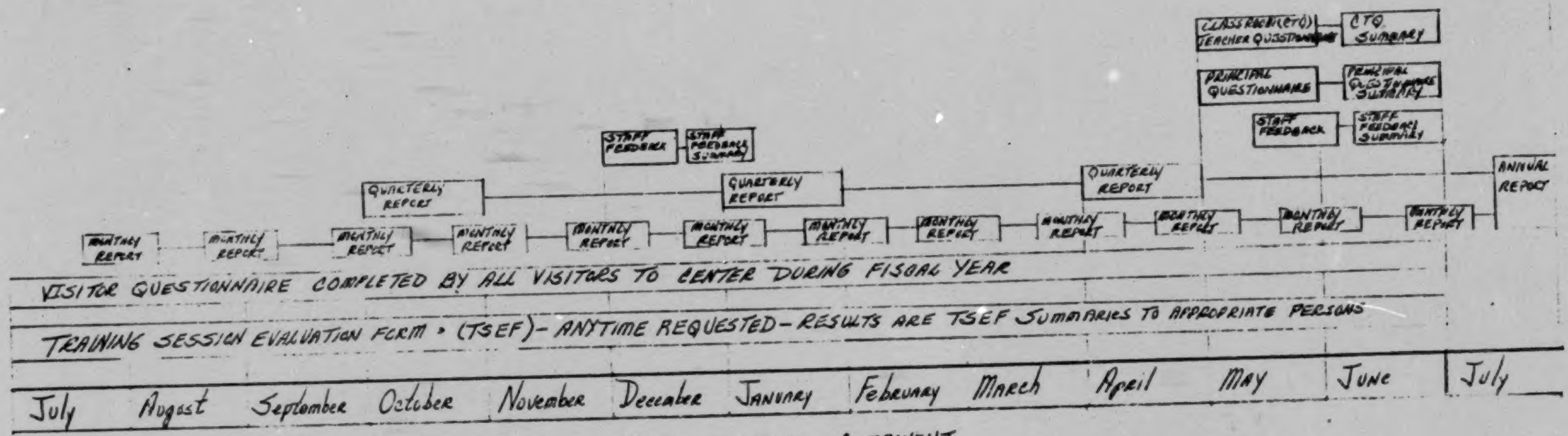

SHORT RORF'S & OTHER SUMMARIES
10th WEEK RORF
RORF SUMMARY
CYGNET SUMMARY COMPLETION
5th WEEK RORF & SUMMARY
BASELINE RORFS-NEW STUDENTS
CYGNET SUMMARY 1st PART
SWAN OBSERVATION & SUMMARY
1st Week
2ND WEEK
3rd WEEK
4th WEEK
5th Week
6th Week
7th Week
8th WEEK
9th Week
10th Week
11th Week
TREATMENT EVALUATION
TREATMENT EVALUATION
TREATMENT EVALUATION
TREATMENT EVALUATION
TREATMENT EVALUATION
RFCLs (and associated plots, bar graphs, and summaries) Collected for Staffing, Termination, and Tracking All Fiscal Year
QUARTERLY REPORT
QUARTERLY REPORT
QUARTERLY REPORT
MONTHLY REPORT
ANNUAL REPORT
Data Collected from Class Rolls, School & Agency Contact Card, Parent Contact Card, Parent Activity Card, and Intake and Referral Records All Fiscal Year
Demographic Data (Summaries of Psychological and Educational Testing and Family and School Information) Collected All Fiscal Year ; Reported December and June
July
August
September
October
November
December
January
Febuary
March
April
May
June
July
Summer Quarter
Fall Quarter
Winter Quarter
Spring Quarter
Summer Quarter
SERVICES TO CHILDREN AND PARENTS
= CLASSES NOT IN SESSION

FIGURE 6

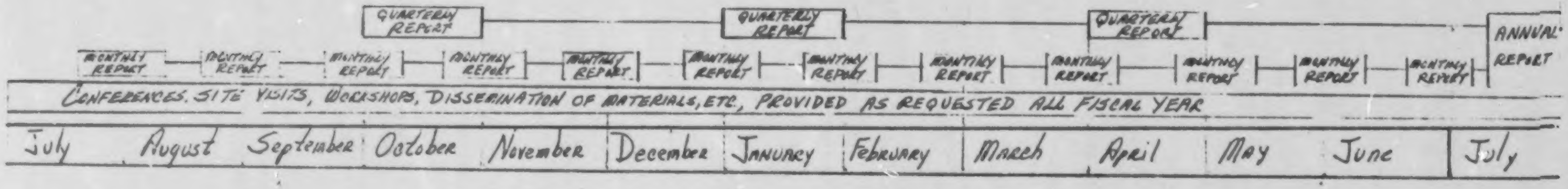
OVERVIEW OF EVALUATION SCHEMA
(continued)


MONTHLY REPORT
MONTHLY REPORT
QUARTERLY REPORT
MONTHLY REPORT
MONTHLY REPORT
STAFF FEEDBACK
STAFF FEEDBACK SUMMARY
MONTHLY REPORT
QUARTERLY REPORT
MONTHLY REPORT
MONTHLY REPORT
MONTHLY REPORT
MONTHLY REPORT
QUARTERLY REPORT
MONTHLY REPORT
CLASSROOM (CTQ) TEACHER QUESTIONNAIRE
CTQ SUMMARY
PRINCIPAL QUESTIONNAIRE
PRINCIPAL QUESTIONNAIRE SUMMARY
STAFF FEEDBACK
STAFF FEEDBACK SUMMARY
MONTHLY REPORT
MONTHLY REPORT
ANNUAL REPORT
VISITOR QUESTIONNAIRE COMPLETED BY ALL VISITORS TO CENTER DURING FISCAL YEAR
TRAINING SESSION EVALUATION FORM • (TSEF) - ANYTIME REQUESTED - RESULTS ARE TSEF SUMMARIES TO APPROPRIATE PERSONS
July
August
September
October
November
December
January
February
March
April
May
June
July

ADMINISTRATION COMPONENT

FIGURE 6

OVERVIEW OF EVALUATION SCHEMA
(continued)


QUARTERLY REPORT
QUARTERLY REPORT
QUARTERLY REPORT
ANNUAL REPORT
MONTHLY REPORT
MONTHLY REPORT
MONTHLY REPORT
MONTHLY REPORT
MONTHLY REPORT
MONTHLY REPORT
MONTHLY REPORT
MONTHLY REPORT
MONTHLY REPORT
MONTHLY REPORT
MONTHLY REPORT
MONTHLY REPORT
CONFERENCES. SITE VISITS, WORKSHOPS, DISSEMINATION OF MATERIALS, ETC, PROVIDED AS REQUESTED ALL FISCAL YEAR
July
August
September
October
November
December
JANUARY
February
March
April
May
June
July

COMMUNICATIONS COMPONENT

an opportunity for involvement in the child's program at the center. With each parent the initiation of the program involves the establishing of an acceptance and concern of the child's problem (s); from an evaluation view-point this involves the planning phase. Following this "tuning-in" period,emphasis is on parent involvement and the documentation of this involvement. Detailed accounts are kept of ways the parents participate in the effort of working with the child. Data collected in connection with the parent program (during the monitoring phase) are in the form of frequency counts and unobtrusive measures--indicators of information shared, parental acceptance, involvement, and activities outside of the center. The appraising phase includes summarizing all of these indicators as well as examining change in parents with respect to awareness of the child's development, work on child's problems, and trust in the center.

More specific details regarding instrumentation and evaluation activities may be found in subsequent chapters.

Communications and Technical Assistance

The goal of the communications component is to demonstrate, through the Technical Assistance Office, the center processes to other professionals and to disseminate professional information to other programs providing services to emotionally disturbed children. The evaluation team assists in planning component activities--time charts for workshops, seminars, consultations, etc., materials to be sent out and/or presented, feedback forms, etc. The data collected during the monitoring phase are in the form of frequency counts and qualitative reports. Of general concern in the appraising phase is determining what impact the center has on various social and professional communities.

Administration

As far as the evaluation effort is concerned the administration component involves implementation and continuation of the Service-to-Children, Service-to-Parents, and Communication programs. Information obtained in monitoring and appraising pertain to an assessment of the degree to which the project adheres to the goals and objectives. Variables of administrative concern are: a) the individuals being served (children, parents, school personnel), b) the center staff, c) treatment process, d) facilities and e) allocation of resources. Such information collected by the evaluation team pertains to in-service training programs, staff feedback on center operations, feedback from local schools, inventories of buildings and equipment, and data on costs of service. Specific details regarding instrumentation and evaluation activities related to administration are included in Chapter One. Questions asked of the staff concerning evaluation are contained in the Appendix, Form 4. Such data provide a highly valuable feedback for center administration. Program modifications based upon such data have helped to keep a close link between various program goals and objectives, evaluation activities, and administrative functions. Details of these evaluation activities are contained, by program, in the following chapters.

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Cronbach, L. J. Course improvement through evaluation. *Teachers College Record*, 1963, *64*, 672-683.

Huberty, C. J., Quirk, J. P., and Swan, W. W. An evaluation system for a psychoeducational treatment program for emotionally disturbed children. *Educational Technology*, 1973. In press.

Luborsky, L. Psychotherapy. *Annual Review of Psychology*, 1959, *10*, 317-344.

Stake, R. E. The countenance of educational evaluation. *Teachers College Record*, 1967, *68*, 523-540.

Chapter Three

REFERRAL AND INTAKE PROCEDURES

Mary Margaret Wood
Lesley Whitson

Although the intake process sounds quite long and involved, it takes only three weeks (approximately) and serves to gather information from a number of sources on a child referred to Rutland Center so that the staff can develop a uniquely suited program for the child and determine if the child can best be served by the Rutland Center program. It is estimated that the entire process takes a total of 12 contact hours, as shown in Table 1.

Table 1

Estimated time to process one child
from Initial Referral
through Staffing

Referral	
Initial Contact if by telephone referral	10 minutes
School or nursery school contact	30 minutes
Screening Committee	15 minutes
total	55 minutes
Intake	
Intake Interview with Parent	60 minutes
Psychological	60 minutes
Educational	60 minutes
Psychiatric Evaluation	45 minutes
School and/or day care or nursery conference	45 minutes
Evaluation Team data summary	30 minutes
Staffing (6 staff members for 30 minutes)	180 minutes
total	480 minutes

Post Staffing

Educational Planning Conference		45 minutes
Parent Conference		60 minutes
	total	105 minutes
	Grand Total-	640 minutes
	approximately	11 hours*

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*This does not include travel time; does not include writing reports and typing them; does not include secretary's time during screening and/or staffing, nor writing appointment letters.

Figure 7 is a flow chart outlining procedures from initiation of a referral, through the diagnostic and intake process, to the final post staff conferences with parents and teachers.

Referrals

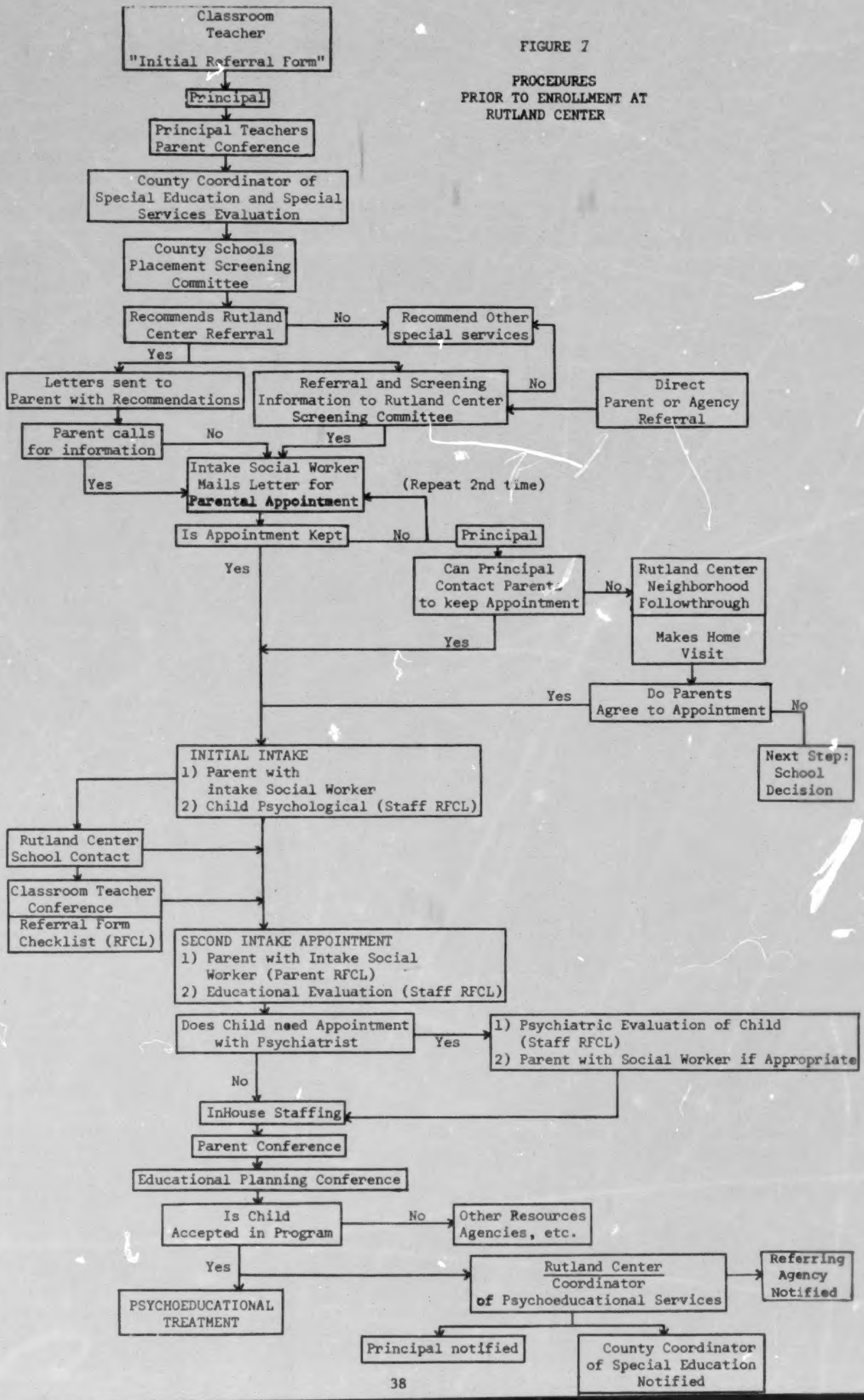
Referrals are accepted from parents, schools, early childhood development programs, or other child-serving agencies. However, no child is seen for any center service without parental approval (signed) and participation in at least one "intake" conference prior to or concomitant with testing of child and one "post-testing" conference summarizing results of testing and recommendations.

Restrictions established to determine those children not accepted for testing are as follows:

1. non-appropriate handicapping conditions or age
2. availability of an alternative resource better suited to the needs, as presented in the referral
3. minor problems, possibly responding to home or school consultation

FIGURE 7

PROCEDURES
PRIOR TO ENROLLMENT AT
RUTLAND CENTER


Classroom Teacher "Initial Referral Form"
Principal
Principal Teachers Parent Conference
County Coordinator of Special Education and Special Services Evaluation
County Schools Placement Screening Committee
Recommends Rutland Center Referral
No
Recommend Other special services
Yes
Letters sent to Parent with Recommendations
Referral and Screening Information to Rutland Center Screening Committee
No
Direct Parent or Agency Referral
Parent calls for information
No
Yes
Yes
Intake Social Worker Mails Letter for Parental Appointment
(Repeat 2nd time)
Is Appointment Kept
No
Principal
Yes
Can Principal Contact Parents to keep Appointment
No
Rutland Center Neighborhood Followthrough
Makes Home Visit
Yes
Yes
Do Parents Agree to Appointment
No
Next Step: School Decision
INITIAL INTAKE
1) Parent with intake Social Worker
2) Child Psychological (Staff RFCL)
Rutland Center School Contact
Classroom Teacher Conference
Referral Form Checklist (RFCL)
SECOND INTAKE APPOINTMENT
1) Parent with Intake Social Worker (Parent RFCL)
2) Educational Evaluation (Staff RFCL)
Does Child need Appointment with Psychiatrist
Yes
1) Psychiatric Evaluation of Child (Staff RFCL)
2) Parent with Social Worker if Appropriate
No
InHouse Staffing
Parent Conference
Educational Planning Conference
Is Child Accepted in Program
No
Other Resources Agencies, etc.
Yes
Rutland Center Coordinator of Psychoeducational Services
Referring Agency Notified
PSYCHOEDUCATIONAL TREATMENT
Principal notified
County Coordinator of Special Education Notified

Referrals are made by schools or directly to the center by parents or other agencies. School referrals are received in written form. The forms are developed by each school sytem. Parent and agency referrals ordinarily are received by telephone and are recorded on the center's Initial Referral Form (Form 5 in the Appendix). These requests are taken by an intake social worker.

Before a referred child is enrolled at Rutland Center, he is involved in three processes, screening, intake, and staffing. These processes provide three decision points between referral and treatment,at any one of which a child can be directed to another resource or program.

Screening

When the child is referred, the request goes to the Screening Committee which is made up of representatives from social services, psychological services, and educational services. This committee discusses the information given on the referral form, decides whether the child should be accepted into the intake process; and, if a child is accepted, assigns the case to an intake social worker and to the Rutland Center county consultant. If a child is not accepted, the intake social worker or a county consultant will notify the referral source, describe reasons, and convey the committee's recommendations concerning alternative programs. This information and decision is always conveyed in a letter and often with a conference too. Screening notes, a brief summary of the screening decisions, are given to each staff member following this meeting and are filed in a permanent screening file.

Intake

A case, having been accepted for intake, then is given to the intake supervisor who makes all appointments for the intake process and keeps all case files during intake. Intake, essentially an information gathering process, involves five to six steps.

1) Intake Interview

The parent is asked to come in for an intake interview. The appointment is made by the intake supervisor and is conducted by an intake social worker. There are five objectives of the intake interview:

a) This is usually the parents' first face-to-face meeting with the Rutland Center staff, and the bond of trust between the parents and the staff can begin here.

b) The intake social worker explains Rutland Center procedures which are important at this point in the process, such as the procedures of the intake process, the fact that there is no charge for Rutland Center services, and the time that might be involved if the child is accepted into the program.

c) In this first meeting, the therapeutic process for child and parent often begins. In gathering further information about parent and child, the parents are offered the opportunity to begin releasing some of the frustration they might be feeling. Often a crisis situation has prompted the referral of the child to Rutland Center, and in getting out some of the feelings surrounding this crisis, a parent may begin to see some hope for his child and family.

d) There are two forms to be filled out during the intake interview. The first form, the Initial Intake Form seeks information such as occupation of parents, number of people living in the home, etc. See Appendix, Form 6. Also on this form, signed permission is received for Rutland Center to contact the child's school or other agencies for further information.

The second form, the Referral Form Check List (RFCL), Section I, is used also. See Appendix, Form 7. This form asks the parents for specific information on what they see as the major problems of their child. There is a section which asks parents to comment also on academic, behavioral or personality strengths and abilities. Not only does this serve to give the Rutland Center staff information about the child and the parent, but also it serves to help the parent begin thinking about the behaviors of his child in a specific manner. Procedures are described in the Appendix, Form 8.

e) Also during this interview, appointments are made for the testing of the referred child.

2-4) Testing

Testing makes up steps two, three, and possibly four of the intake process. Each child is tested by an educational diagnostician and a psychologist. If necessary, the child may also receive a psychiatric evaluation. These tests are not generally given on the same day. In the testing process each person at the center who tests the child also will fill out the RFCL, sections one and two. Section two is included in the Appendix, Form 9 along with definitions of terms used on the RFCL, Form 10. Staff should become thoroughly familiar with these definitions in order to assist parents and teachers with clarifications when needed.

5) School Contact

Step five of the Intake process involves gathering information on the referred child from his public school teacher. A Rutland Center county consultant, one of the members of the Field Services Component, will go to the school at an appointed time and talk with the teachers of the referred child.

During this interview no confidential material is given to the teacher, but she is given the opportunity to discuss at length the problems the child is presenting at school. Should the referral have originated with the parents, the teacher is made aware that the referred child is in the intake process at Rutland Center. When contacting the child's regular teacher, a number of informational type questions to ask of the teacher can provide a valuable source for subsequent planning for the child.

1. At what can he succeed?
2. At what does he fail and how important is it to him?
3. What has a quieting effect on him?
4. What stimulates, excites, or angers him?
5. Of what or whom is he afraid?
6. What does he consider fun?
7. What were his previous school experiences like?
8. How is he accepted by a group?
9. How does he feel about the other children -- who are his friends?
10. Can or does he work independently and why?
11. Does he have any outstanding physical characteristics - normal amount of energy?
12. At what grade level is he functioning in each academic area?
13. What reading and arithmetic books is he using?
14. Does he have a particular way he learns better than another?
15. Can he retain what he has learned?
16. What is his regular class schedule and routine?

At this time, the teacher will be asked to fill out the RFCL, Section I, on the child. Procedures for administering the RFCL in schools are contained as Form 8 in the Appendix.

Referral Form Check List (RFCL)

The Referral Form Check List (RFCL) is a composite of behavior problems abstracted from referral records accumulated over a two-year period. The treatment files were reviewed, and all referral problems for preschool and primary school children were listed. Over 200 behavior problems were recorded; from this list many were eliminated because of duplication of problem meaning. This synthesis resulted in the check list, which is composed of 54 behavior problems grouped within the four curriculum areas of Developmental Therapy. A review of the literature indicated that the RFCL contained characteristics which are identical or parallel to those that have been previously investigated. A five-point rating scale format, ranging from "High Priority Problem" to "Not a Problem or Not Noticed" was selected because such a change format (a) provides a range for detection of behavioral change over a period of time, (b) allows for recognition of problems perceived by adults as "real" adjustment problems, and (c) permits the incorporation of clinical inference in the judgment process.

Inter-observer reliability estimates have been obtained using an intra-professional group orientation. Initial results are encouraging. Reliability estimates range from .75 to .91 across professional groups.* The RFCL, Section I for parents and teacher, is contained in the Appendix as Form 7.

Referral Form Check List Summary

The RFCL represents a common point of focus for all staff members working with the child and family. Each staff person who sees the child fills out this form independently, and together with the parent and teacher, the responses are summarized into a composite picture by the Evaluation staff and reported on the Referral Form Checklist Profile Analysis Plot and the RFCL Bar Graph. See Appendix, Forms 11 and 12.

Staffing

After all of the information from the intake process has been collected the referred child is staffed; that is, a meeting (staffing) is held, including all the staff members who have had, or possibly will have, contact with the referred child. A regularly scheduled weekly time is set aside each week for staffings. The intake supervisor schedules approximately four cases to be staffed each week.

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*A complete description of this instrument, its development and use is found in "An Evaluation System for a Psychoeducational Treatment Program for Emotionally Disturbed Children" in Educational Technology, 1973, by Huberty, C. J., Quirk, J. P., and Swan, W. W.

At the staffing all of the information which has been gathered is presented.

1) A report is given by the center staff person who contacted the school and gathered information from child's regular school teacher. Included in the school contact report are:

   a. the teacher's perception of the child's needs (Rutland Center program, regular classroom help, parent help);*

   b. the time the teacher will be available for short meetings or observations; and

   c. the time the child might be able to be away from his regular class to come to the Center.

2) The RFCL Profile Analysis and bar graph are reviewed, pointing out the high priority problems as seen from the various raters and specifying the identifying source (parent, teacher, staff, etc.)

3) The intake social worker gives a report on findings from the intake interview, which includes facts given by the parents and impressions gained by the intake social worker during the interview.

4) Reports are given by the psychologist, educational evaluator, and psychiatrist (if he has seen the child), including test results, impressions gained during the

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* A discussion of school contacts is provided in Chapter Six.

testing procedure, and recommendations as to whether the child should be accepted at the Rutland Center. These reports become a part of the child's confidential folder. The Educational Assessment form is contained in the Appendix, Form 13. Guidelines for conducting the educational assessment are attached as Form 14. Form 15 is used to summarize psychological testing results. Narrative reports by the social worker, the psychiatrist and psychologist also are prepared for the confidential folder.

5) A summary of the prognosis, the degree of severity and the suspected clinical diagnosis of the child as seen by the psychologist, educational evaluator, and the psychiatrist (if he has been consulted) is presented. See Appendix, Form 16.

After the information has been presented, the case is discussed by the staff. The discussion focuses on the needs of the child and family and whether or not he or she would benefit from the Rutland Center program.

If it is decided that the child would not benefit from the Rutland Center program, recommendations are made which will be related to the parent by the intake social worker who conducted the initial intake interview. These recommendations often involve suggestions for the school, the home, or referral to another agency. A parent planning conference with the parents and an educational planning conference with the school are set up after the staffing, so that test results and recommendations can be relayed. The procedures for this are described in the section "Procedures After Staffing".

If it is decided that the child would benefit from the Rutland Center program, the process of actually planning for enrolling the child into the Developmental Therapy program begins at the staffing. To complete program recommendations at staffing, the following steps are taken.

1. The staff determines the child's level of Developmental Therapy in Behavior, Communication, Socialization, and (pre) Academics, according to the Developmental Therapy Representative Objectives. The child is placed in a class according to

his most representative level of development, considering the four curriculum areas. For example, if a child has not mastered developmental milestones for Level 1 in School Readiness, Socialization and Behavior, but has mastered many of the developmental milestones of Level 2 in Communication, he will be given individual experiences at his own level for Communication objectives.

2. The staff proposes specific developmental treatment objectives for the child as he begins treatment.
3. The staff estimates a projected period of time that the child will remain in the program. For example, a child placed in Level 1 might be expected to remain in the program for four ten-week treatment periods. This projection is made for two reasons. First, this projection, when relayed to the parents serves to give them knowledge that (a) success and change will not occur overnight, and (b) there is an end in sight for them to work

towards. Second, the projection can be quite useful for the staff in evaluating progress made with a child. If the projection for the child is four ten-week periods and at the end of two periods the child is farther than half way from the end of treatment, it might serve as a signal for the staff to re-evaluate their treatment strategies for that child. Of course, this projection is extremely flexible and should not be taken as a fixed boundary by either parents or staff. It serves merely as a guide for progress in the treatment program.

4. The staff decides on possible strategies for school and parent intervention. Since major treatment objectives for the child at Rutland Center have been suggested, parents and teachers should be informed of these and asked for their reactions. Their aid and involvement in planning and implementing programs around these objectives at home and at school will

be necessary for a successful program. In particular, specific recommendations are made at staffing concerning the amount and type of parental involvement the staff should work for. Parent services are described in more detail in Chapter 7, Services to Parents.

The staffing procedure provides the framework for a careful selection of child, parent, and school recommendations, taking advantage of what we know about developmental growth, problem behavior, and learning characteristics of children. The foregoing outline simply provides the structure for reaching decisions and making recommendations. It suggests that children called "emotionally disturbed" are different from each other in terms of developmental levels, strengths, educational needs, and parent procedures, but that each area of difference contains important and useful implications for child treatment.

The Treatment Sheet

To facilitate program planning and subsequent monitoring, the staffing information is recorded on a three-column treatment sheet. The first column contains the RFCL high priority problems as identified by all raters. The second column contains the suggested causative factors underlying the behavior problems. The treatment sheet also outlines the entry level for Developmental Therapy and treatment focus, with specific suggestions for developmental objectives needing emphasis. Recommendations for amount of parent participation are also specified on the treatment sheet. Having these treatment sheets available for program monitors has been found to be invaluable in providing a framework within which to observe the child and evaluate his progress in the treatment program. A copy of the treatment sheet is contained in the Appendix, Form 16.

Structuring of the diagnostic staffings in this way has been immensely helpful in specifying the needs of a child, setting treatment goals, and outlining treatment procedures. All of these are necessary for the effective evaluation of any program.

Procedures After Staffing

Children who are not accepted in the Rutland Center program are not left without help. It is the responsibility of the intake social worker and the Coordinator of Liaison and Field Service to provide for any follow up services that might be needed. Usually two conferences are held following staffing concerning the child: the Parent Planning Conference with the child's parents and the Educational Planning Conference with the child's school. Occasionally these conferences are conducted together. Results and recommendations made at staffing are presented to those involved with the child, the school and the parents. Usually the educational diagnostician or county consultant conducts the educational planning conference for the children not accepted. Follow-up activities for families of children not accepted, such as to community agency, physician or for parent help,are carried out by the intake social worker. Occasionally, parents of children not accepted may be helped by participating in a Rutland Center Parent Training Program. The intake social worker can arrange for a specific treatment team to work with the parents for short-term training.

If a child is accepted for the Rutland Center program, a Parent Planning Conference and Educational Planning Conference also must be held. At the onset of the treatment program, two important processes take place: (a) the parents and the teacher of the child are brought in on the actual planning and implementation of the treatment program, and (b) a transfer for the parents is made from the intake social worker to the treatment team monitor.

Parent Planning Conference

When a child is accepted into Rutland Center, a Parent Planning Conference is held with the parents, with the intake social worker, and with the treatment team monitor who will work with the parents. The intake supervisor is responsible for making the appointment, and the intake social worker usually conducts the conference.

The Parent Planning Conference has four major goals:

1) to communicate to the parents the test results and recommendations made by the Rutland Center staff;
2) to discuss the meaning of these results and recommendations with the parents for clarification;
3) to establish a communication link between the monitor and the parent;
4) to plan cooperatively the programs to be conducted at Rutland Center and at home.

Figure 8 outlines suggested steps for conducting such a Parent Planning Conference.

Figure 8

SUGGESTED STEPS FOR CONDUCTING A PARENT PLANNING CONFERENCE

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1) Report test results and recommendations

    a) Summarize the RFCL Profile, pointing out the priority problems as seen by parents, teachers, and staff.

    b) Summarize psychological, educational, and psychiatric testing results.

    c) Review recommended major treatment objectives as related to the four curriculum areas and stages of Developmental Therapy.

    d) Summarize recommendations for school, Rutland Center, and home.

2) Discuss with parents the meaning of the test results and their long term implications for home and school. This discussion is of great importance to parents. All parents are concerned with the future of their children; perhaps this is especially true of parents of emotionally disturbed children. During this discussion, the Rutland Center staff hopes to begin to build a bond of trust between the staff and the parents because the staff, too, is concerned about the future of each child.

3) Discuss projected treatment time and progress. The projected treatment time is presented to parents as a tentative reference point. At Rutland Center there are 10 week treatment periods. At the end of each 10 week period, each child is re-evaluated on the Developmental Therapy Representative Objectives as to the progress he has made while in the treatment program and a special 10th week conference with parents is held.

Figure 8 continued

Figure 8 continued

4) A decision should be reached by the parents as to whether or not they want their child to participate in the recommended Rutland Center program. This decision rests entirely with the parents and staff should never make the assumption that parents automatically agree. If parents do not agree to participation, the door should be left open to future contacts and the school appraised of the parents' decision. If parents agree, the conference should continue into a discussion of the parents' own involvement.

5) Discussion of home involvement. At this point in the conference, a handbook is given to the parents to read and discuss with the intake social worker and the monitor. The handbook is designed to stimulate discussion and to outline possibilities for parent participation at Rutland Center. Parents are encouraged to take the booklet home. Often this book is used as a take-off point for subsequent conferences.

In the handbook, the questions on pages 6 - 9 are designed to stimulate parent interest and involvement in the program of Developmental Therapy: Behavior, Communication, Socialization, and Academics. The handbook is intended to convey to parents the concept that they are seen as active partners in the treatment process. The fifth question in each curriculum area can be used to lead into a discussion of the major treatment objectives which have been decided upon in staffing for the child's Developmental Therapy program. Page 11 of the handbook is designed to elicit from the parents which of the major focus objectives they feel are the most important for their child, so that the staff and the parents can begin moving in the same direction.

On page 15 of the handbook, specific parent programs are briefly described. These descriptions aid the parent in identifying the specific type of involvement they want and suit it to their own needs and limitations of time, energy, or interest. The programs are discussed to the extent that parents show interest.

Figure 8 continued

Figure 8 continued

It is hoped that the parents make a commitment as to the type of program they would like at this point, but some parents will need time to discuss and plan their involvement at home. If this is the case, then a date and time for the next meeting is planned, and a specific program can be discussed at that time.

6) During this latter part of the discussion, the monitor usually assumes leadership for the conference. This is the person the parents will be working with from this point on, and at this time the transfer should be made from the intake social worker to the monitor.

7) At the end of the Parent Planning Conference, the monitor usually reminds the parents of the time and place of their next appointment. The monitor's name is written on page 17 of the handbook, which also lists the center's phone number.

8) This is the last contact that the parents will have with the intake social worker, who conveys that the transfer to the monitor will be rewarding for the center and the parents in the sense of getting into the actual process of helping the child.

9) The conference is recorded on a Parent Participation Card by the intake social worker and by the monitor jointly.

The Educational Planning Conference

The Educational Planning Conference is conducted by the lead teacher of the treatment team to whom the child has been assigned at staffing. If the child is from a rural county served by field center, the county consultant would conduct the educational planning conference when a child is not accepted.

The purpose of this meeting is to present the results of testing and recommendations made by the Rutland Center staff and to help the school plan a supportive program for the child. The staff and county consultant will be available to help the school in implementing the child's school program.*

The following steps provide guidelines for conducting an educational planning conference:

1. Review diagnostic folder and staffing treatment sheet prior to meeting.
2. Introduce participants and discuss reason for the planning conference.
3. Review presenting problems as identified by by the teacher on the RFCL.
4. Summarize testing results (family interview report is not reviewed ordinarily).
5. Outline staffing recommendations focusing upon Developmental Therapy stage and major treatment objectives.
6. Discuss problems school is having and explore ways problems can be tackled in light of staffing recommendations.
7. Discuss recommended date and time for child to start at the center. The time should be acceptable to the teacher; if she feels the proposed time will impair her program and progress, alternatives should be considered. Transportation

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*School Followthrough is discussed in Chapter Six.

arrangements should be discussed in detail. It is important that these details are completed for children about to enter and a contact person at school be identified.

8. In closing the educational planning conference review the following: review date child is to start; when and where he will be picked up and returned; the name of the team member who will be doing school liaison work; encourage the participants to return for an observation of the child's program; and mention both weekly school contacts and the 10th week conference.
9. Always walk the participants to the door. Offer to show them the building if this is their first visit.
10. Immediately after the conference, fill out a School or Agency Contact Card and return the child's folder for filing.

Availability of Records

In addition to the routinely scheduled meetings to convey information, special requests for information are honored in the following ways:

1. Testing information, staff recommendations, and treatment progress data are available in conference to parents or legal guardian upon request.
2. Testing information and staff recommendations are sent to other professionals providing services to the child only if the parents or legal guardian make this request in writing to the center.
3. Special conferences with staff members to review and discuss center records or procedures can be arranged upon request by a child's parents or legal guardian.

Chapter Four

DEVELOPMENTAL THERAPY*

Mary Margaret Wood

Introduction

Developmental Therapy is a psychoeducational approach to therapeutic intervention with young children who have serious emotional and behavioral disorders. The approach has particular reference to children between the ages of two and eight years and is applicable to children of varying ethnic and socio-economic groups. These procedures have been used successfully also with children to age fourteen.

Developmental Therapy is designed for special education or mental health workers, parents, volunteers, and paraprofessionals using the therapeutic classroom setting with five to eight children in a group. It is a treatment process which (a) does not isolate the disturbed child from the main stream of normal experiences; (b) uses normal changes in development as a means to expedite the therapeutic process;

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(c) uses normal sequences of development to guide the therapeutic process; and (d) has an evaluation system as a part of the therapeutic process.

Field trials were conducted for two years in a university Special Education Clinic, a year in a public psychiatric clinic for children, and two years in a children's psychoeducational center operated as part of a developing Comprehensive Community Mental Health Center. This latter setting offered the most effective arrangement for obtaining rapid treatment results; for meeting professional manpower shortages; for training of volunteers, paraprofessionals and parents; and for helping parents and teachers maintain the child in normal childhood settings during the treatment process.

The theoretical framework for Developmental Therapy is constructed from a number of major works, theory and research, in the fields of child development, child psychopathology, developmental psychology, special education, and learning theories. Results of such studies have led to the formulation of certain assumptions concerning the nature of emotional disturbance in children which have direct implication for child therapy.

Assumption: 1. Emotional and behavioral disturbances in a young child are interwoven with normal functioning and often are difficult to differentiate. (Lapouse and Monk, 1958; Shepherd, Oppenheim, and Mitchell, 1966)

Implication for Therapy: Because of this interweaving of normal and disturbed functions, a plan of therapeutic intervention must include normal experiences and actively involve both normal and disturbed elements within a child.

Assumption: 2. Normal processes of physical and psychological development follow in a hierarchy of stages and sequences well documented in the literature. These sequences produce natural, striking changes during the growth process. Often these normal changes introduce an entirely new array of behaviors and skills in relatively short periods of time. Change and new behavior will occur spontaneously in normal and disturbed children alike. (Anthony, 1970; Hewett, 1968; Parten, 1932)

Implication for Therapy: Utilizing change and new behavior is the key to successful therapeutic intervention. Constructive change occurs when nonconstructive, maladaptive behavior is disrupted, not permitted to continue, and when developmentally appropriate behavior is substituted.

Assumption: 3. The normal process of change is uniquely individual, yet predictable, and occurs in relation to environmental conditions, to experiences, to biological constituents, and to the foundation laid in prior experience. (Baumrind, 1967; Lewis, 1970; MacFarlane, 1943)

Implication for Therapy: The therapeutic process for growth and change should be planned in relation to two standards: (a) maturation of the disturbed child as related to all children, *i.e.*, the general sequence of normal development and the presence and absence of key developmental milestones; and (b) the individual patterns of development, strengths and weaknesses.

Assumption: 4. The young child's knowledge of himself, his confidence in himself, his willingness to risk himself in new situations, grows out of significant, pleasurable experiences. (Hill and Sarason, 1966; Keister, 1938)

Implication for Therapy: Therapy must provide a way for the child to have a toehold of success and the therapist must be able to mirror this success for him to see. If therapy experiences tend to be pleasurable, a child will assimilate the learning. If the experiences are frightening, confusing, complicated, meaningless, or failure-producing, he may tend to avoid a repeat, or negative learning may occur.

Assumption: 5. The young child learns and grows by experiences. What he does is often more significant than what he hears. What he experiences will have impact on what he learns. Meaning comes through experience. (Montessori, 1912; Rhodes, 1963)

Implication for Therapy: Therapy for children implies an essentially experiential emphasis, learning through experiences rather than words. Child therapy must have relevance to the child's

> world beyond the clinic, also. The child must associate particular responses, learned at the clinic, with satisfying results transferred to real life experiences.

Developmental Therapy is a psychoeducational treatment paradigm built upon these assumptions. The process is seen as a developmental progression in which the elimination of pathological behavior and the stimulation of developmentally appropriate behavior is closely akin to normal sequences. By systematically utilizing developmentally suitable experiences in the therapy program, the occurrence of constructive behaviors is stimulated, particularly when experiences represent small, sequential steps toward normal maturation and development. Similarly, nonconstructive behaviors are redirected, outgrown, or extinguished as a child learns more rewarding and satisfying adaptations to his world.

Direction for developing the framework which serves as a guide to the maturational progression in Developmental Therapy has been provided by a number of major developmental theories. Bender (1956), Gesell and Amatruda (1941), Hebb (1949), and Werner (1957) formulated significant psychobiological concepts of normal and abnormal development. The monumental programs of research conducted by Bruner (1966), Inhelder (1957), and Piaget (1967) on cognitive development are the foundations for the entire field of Developmental Psychology. These contributions have relevance for planning maturational experiences for disturbed children as well as for normal children. Similarly, psychosocial aspects of development, particularly as presented by Anthony (1970), Erikson (1959), and Kagan and Moss (1962), cannot be overlooked when considering a developmental approach to child treatment. The works of Krathwahl, Bloom and Masia (1964), Turiel (1969), and Wolff (1960) offer considerable direction in affective and moral development. From aspects of these major writings, Developmental Therapy, the therapeutic curriculum, the stages of therapy, and the developmental objectives for planning and evaluating a child's progress have been formulated.

Developmental Therapy Curriculum

A Therapeutic Curriculum

Curriculum is understood to be a course of study, and as such the Developmental Therapy curriculum represents areas of learning, and sequences to be learned within areas, which produce therapeutic growth. The desired result of this course of study for a young disturbed child is greater effectiveness and comfort in his natural environments: home and school.

The purpose in developing a therapeutic curriculum is to provide a broad outline to guide the therapist in planning appropriate sequences of experiences for the disturbed preschool child. The specific use of the curriculum concept as a therapy guide resulted from early pilot testing of Developmental Therapy. Teachers showed promise as therapists when given adequate guidelines and specific training to implement these guidelines.

Several standards were used in constructing the Developmental Therapy curriculum.

1. The curriculum should be broad enough to cover any serious emotional or behavioral problems seen in the young preschool disturbed child.
2. The curriculum should provide for sequences of experiences which both stimulate growth and utilize new skills as they spontaneously emerge in the child.
3. The curriculum should be adaptable to individual differences but effective and applicable in a group setting.
4. The curriculum should be broad enough to allow for clinical inference and for parent and teacher judgments, yet specific enough to provide objective evaluation.
5. The curriculum should include several essential processes:

> a process for meaningful experiences, not dependent upon verbal ability; a process for constructive learning; a process appropriate to a child's individual sequence of maturation; a process appropriate to the sequence of normal maturation for all children.

Utilizing these standards, the current version of the Developmental Therapy curriculum emerged. This course of study contains four basic curriculum areas: Behavior, Communication, Socialization, and (Pre) Academics. These areas are proving adequate to encompass the varied presenting problems of the **seriously** disturbed school child and to provide a logical entry for the therapist into selection and simulation of normal childhood experiences when planning the treatment program. By establishing therapeutic goals within each area and following the outlined treatment sequences, the therapist can facilitate growth of cognitive, affective and sensorimotor abilities while reducing or eliminating pathological and nonconstructive behavior. With Developmental Therapy the therapist assists the child in the assimilation of selected experiences designed to facilitate the emergence of constructive behaviors. Educational materials and techniques are used as vehicles for implementing the process.

Stages of Developmental Therapy

As the four areas of the therapeutic curriculum were applied successfully to small groups of young disturbed children, it became apparent that general therapeutic goals within each area could be established following developmental sequences. These sequences suggest five rather distinct stages of therapy. Each stage requires a different emphasis, different techniques, and different materials and experiences. Progress through these five stages, in each area of the curriculum, results in an increasingly well adjusted child. A summary of these Developmental Therapy stages is presented in Figure 9. Therapeutic goals for each area of the curriculum at each stage of therapy, are presented in Figure 10.

These stages represent an integration of developmental aspects of psychobiological, psychosocial, cognitive, affective, and moral systems. The steps are applicable across ages, range of problems, and socio-economic conditions of seriously disturbed children. Each stage is translated into the four areas of curriculum, and an individual child may be in different stages of therapy with each of the four curriculum areas. Each child will progress at varying rates through the developmental hierarchy within each curriculum area. The therapist's role, the amount

Figure 9

SUMMARY OF DEVELOPMENTAL THERAPY STAGES

STAGE I: Responding to the Environment with Pleasure

General Description: Responding and Trusting

THERAPIST'S ROLE: Arouser and satisfier of basic needs

TECHNIQUES: Body language, controlled vocabulary, routine, stimulating activities

INTERVENTION: Constant physical contact, caring, arousing

ENVIRONMENT AND EXPERIENCES: Routine constant, luring rather than demanding, stimulating, arousing activities (sensory)

STAGE II: Responding to the Environment with Success

General Description: Learning Individual Skills

THERAPIST'S ROLE: Verbal reflector of success, redirector of old coping behaviors to successful outcomes

TECHNIQUES: Routine, consistency, holding limits, redirection

INTERVENTION: Frequent, both physical and verbal

ENVIRONMENT AND EXPERIENCES: Activities leading to self-confidence, communication activities; success, free play time, and structured play

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STAGE III: Learning Skills for Successful Group Participation

General Description: Applying Individual Skills to Group Procedures

THERAPIST'S ROLE: Reflector of feelings and progress; encourager; holder of limits

TECHNIQUES: Reflection of feelings; predictability; frequent verbal intervention, consistency

INTERVENTION: Frequent, group focus, mostly verbal

ENVIRONMENT AND EXPERIENCES: Focus on rules; focus on group; focus on consequences of behavior; approximate real life as much as group can tolerate; predictable structure; sharing

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STAGE IV: Investing in Group Processes

General Description: Valuing One's Group

THERAPIST'S ROLE: Reflector of reality and success; counselor group leader

TECHNIQUES: Reality reflection, individual LSI, group discussions aimed at problem solving, group planning

INTERVENTION: Intermittent, approximating real life

ENVIRONMENT AND EXPERIENCES: Approximates real life with normal expectations; Emphasis on learning experiences, unsimulated normal expectations, role play, field trips, plans developed by children

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STAGE V: Applying Individual/Group Skills in New Situations

General Description: Generalizing and Valuing

THERAPIST'S ROLE: Counselor, teacher, friend

TECHNIQUES: Normal expectations; relationships between feelings, behaviors, and consequences non clinical

INTERVENTION: Infrequent

ENVIRONMENT AND EXPERIENCES: Normal childhood settings; conversations about real life experiences; support in solving problem situations; independent skill building

Figure 10

DEVELOPMENTAL THERAPY GOALS FOR EACH CURRICULUM AREA AT EACH STAGE OF THERAPY

	BEHAVIOR	COMMUNICATION	SOCIALIZATION	ACADEMIC SKILLS
STAGE I	To trust own body and skills	To use words to gain needs	To trust an adult sufficiently to respond to him	To respond to the environment with processes of classification, discrimination, basic receptive language concepts, and body coordination
STAGE II	To successfully participate in routines	To use words to affect others in constructive ways	To participate in activities with others	To participate in classroom routines with language concepts of similarities and differences, labels, use, color; numerical processes of ordering and classifying; and body coordination
STAGE III	To apply individual skills in group processes	To use words to express oneself in the group	To find satisfaction in group activities	To participate in the group with basic expressive language concepts; symbolic representation of experiences and concepts; functional semi-concrete concepts of conservation; and body coordination
STAGE IV	To contribute individual effort to group success	To use words to express awareness of relationship between feelings and behavior in self and others	To participate spontaneously and successfully as a group member	To successfully use signs and symbols in formalized school work and in group experiences
STAGE V	To respond to critical life experiences with adaptive-constructive behavior	To use words to establish and enrich relationships	To initiate and maintain effective peer group relationships independently	To successfully use signs and symbols for formalized school experiences and personal enrichment

of intervention required, the types of simulated environment and experiences needed, and the amount of participation change with each stage. The following sections provide a general description of each stage of therapy.

Stage I: Responding to the Environment with Pleasure

The disturbed child first entering the program does not trust his surroundings or himself. He may be immobilized from constructive activity, retreating into helpless, regressive behavior or acting out in rage.

The first stage of treatment must arouse and mobilize the child to respond to the environment, to trust the therapist, and to trust himself enough to venture forth. Stage I focuses upon these processes until the child has mastered each with proficiency. Standards for mastery of these processes vary with chronological age and different types of emotional and behavioral problems. Criteria for mastery of each stage are based upon individual as well as normative standards of child development. However, the objectives are applicable to any chronological age. Children will move through this stage at widely varying rates: one week to one year.

The therapist's role at Stage I is defined as the "arouser", the adult who will provide satisfactions and pleasures under certain conditions, communicated through acceptance, nurturance, and body language.

Experiences selected for children at this stage emphasize sensory arousal: smelling, testing, touching, hearing - always simulating age appropriate conditions to the extent possible. Activities are planned to move the child from diffused to selective responding. Experiences need to be predictable, simple, and familiar. Repetition of experience is essential. The classroom organization is less structured than at other stages and the activities are less formal.

A minimum requirement for participation at this stage of therapy is two hours each day, five days a week. Concomitant enrollment in a regular school or preschool at this stage of therapy may not be recommended. Exposure to a variety of children, adults, materials and expectations tends to compound the complexities of the child's world and may work against initial mobilization.

During the first stage of therapy the quality of the child's response is not a major concern. General therapeutic goals for each area of the curriculum are:

Behavior: to trust own body and skills

Communication: to use words to gain needs

Socialization: to trust an adult sufficiently to respond to him

Pre-academics: to respond to the environment with processes of classification, discrimination, basic receptive language, and body coordination

When a child accomplishes these goals, he is ready to progress from the first stage to the next stage of therapy. In the area of behavior, spontaneous, constructive responses have been mobilized. In communication, the child has begun using words to obtain needs. In socialization, the child can trust the adult sufficiently to seek him out spontaneously and to accept his touch. For **pre-academics** the child has mastered fundamental cognitive skills of discrimination, classification, and enumeration, expressed with increased eye-hand and general body coordination.

Mastery of this first stage of Developmental Therapy is seen as the primary step in the mobilization of the child's resources for the treatment process. The basic elements for constructive behavior are mobilized: awareness, attention, responding, and feeling good about one's self in the therapeutic setting. The child has made a significant movement in the therapeutic program by responding to the adult and the therapeutic environment. The accomplishment of the general therapeutic goals of Stage I prepares a child with the rudimentary foundations for progress in Stage II where emerging behaviors become more organized.

Stage II: Responding to the Environment with Success

This second stage of Developmental Therapy emphasizes learning individual skills, meaningful organization, classroom routine, successful exploration, and testing. The child explores, organizes, and masters new but uncomplicated experiences. Responses learned at Stage I are channelled into individual successes and skills at Stage II. For some children this stage of treatment may represent discomfort, conflict, and insecurity as inappropriate behaviors are redirected and individual skills are taught. The child may revert to old coping behaviors temporarily. Then it is important that the therapist remobilize the child to appropriate behavior, reducing inappropriate behavior to a minimum. The therapist's role during this stage of therapy is defined as the predictable point of reference, reflecting success, holding limits, while encouraging exploration. Considerable physical intervention on the therapist's part is still required.

For this second stage of Developmental Therapy, general treatment goals for each area of the curriculum are:

Behavior: to see oneself as successful participator in routines

Communication: to use words to affect others in constructive ways

Socialization: to participate in activities with others

Pre-academics: to participate in classroom routine with language concepts of similarities and differences, labels, use, color; numerical processes of ordering and classifying; and body coordination

At Stage II, children are not yet able to see themselves as a member of a group. Yet simple group experiences at this stage are essential to accomplish individual goals. Within the group, the child's receptivity for change must be sensitively directed into new, successful experiences. It is important that the therapist reduce to a minimum opportunities for regressive or other inappropriate behavior. This stage is a critical one for learning new, appropriate behaviors and skills.

Stage II can be viewed as an organizing effort requiring elements of structure, consistency, routine, and predictability, with many experiences for exploring and testing new skills. The therapist must carefully sequence these new experiences and each new confrontation so that the child sees himself as an individual with some basic capacity to accomplish and master the situation. The therapeutic classroom simulates experiences which help the child to grow in individual skills which will eventually generalize into new, broader competencies. Individualized instruction is planned for teaching academic (or pre-academic) skills but is conducted in a group setting. Frequently programmed instruction is used at this stage in contrast to Stage III where it is used less often.

At this stage children generally are ineffective in communication. This necessitates a systematic, simplified sequencing of experiences which increase in communication complexities when the child shows he is able to handle less complex situations comfortably. Too much language with too little specificity, lacking concreteness, will slow down the therapeutic process. The child may not be able to assimilate new meanings from such experiences.

During this stage of therapy it is essential that the therapeutic class be conducted at least four days a week, for two hour sessions each day. Concomitant enrollment in a regular school, preschool, or kindergarten program generally should be started. Children who have not had ongoing, normal group experiences during Stage II of therapy seem to move more slowly through Stage III. However, a child should not be placed in a regular program if the developmental discrepancies are so great as to create further stress.

A child is ready to leave this class for the next level class when he has learned to direct his own behavior constructively with only intermittent intervention from the therapist; when he uses words spontaneously for interpersonal communication; when he is not afraid to participate in activities with others, and; when he is confident that there are play and work activities he can do successfully.

Stage III: Learning Skills for Successful Group Participation

Stage III represents a turning point in the therapeutic environment, in the therapist's role, and in the type of experiences selected for the child's program. In contrast to Stage II where extrinsic control and structure are paramount, Stage III begins the critical movement of assimilation within the child himself. In this stage of therapy the child is provided with situations and experiences where he can apply newly mastered skills and concepts, especially with the peer group. He begins to assimilate the results of his experiences. He learns to tolerate some failure and to utilize a failure experience for future success.

The therapeutic classroom at this stage has a group emphasis, and the members of the group have mastered essential individual skills as prerequisites for group participation. Less structure is required to elicit participation and the group is encouraged to develop and maintain its own rules, regulations, and consequences.

The therapist functions as the group leader, as the adult who can recognize and reflect real success, and as the person who can provide direction for the individual child who may falter within the group setting. Intervention on the therapist's part is intermittent and direct physical intervention is seldom necessary.

Both group and individual experiences for this stage of therapy are selected to prepare the child for a comfortable transition to a regular school program. When experiences are planned within the therapeutic classroom setting, the activities, expectations, materials and processes more closely simulate real-life situations than at previous stages of therapy. It is essential for the therapist to resist accepting inappropriate behavior at this stage of therapy. Should such behavior persist, the child is reassigned to an age appropriate group functioning at a lower stage of therapy.

The group at Stage III generally requires a program three to four times a week, and sessions usually are an hour and a half in duration. Concomitant enrollment in a regular preschool or school program is essential for all children at this stage of therapy. This arrangement will be facilitated if the child has been enrolled in a regular program during the previous stage of therapy.

For Stage III of Developmental Therapy, the goals for each area of the curriculum are:

Behavior: to apply individual skills in group processes

Communication: to use words to express oneself in the group

Socialization: to find satisfaction in group activities

Academics: to participate in the group with expressive language concepts; symbolic representation of experiences and concepts; functional, semi-concrete concepts of conservation; and body coordination

With the mastery of Stage III the child exhibits an emerging sense of self. He is able to regulate his own behavior with decreasing need for outside controls. Expression of emotion has fallen under greater self direction and in a verbal rather than a behavioral medium. The child has attached value to the group and is willing to invest himself in appropriate group behavior. Facilitating all of these accomplishments is the child's ability to use symbols for representation of his personal experiences with an emerging sense of self knowledge and self worth.

Stage IV: Investing in Group Processes

Children participating in Developmental Therapy at Stage IV need a less clinical, contrived environment and a more reality oriented one. When they enter this stage, their individual skills and abilities, however modest, are held by themselves and others to be adequate, in behavior, socialization, communication, and school work. The task to be accomplished at Stage IV is one of enlarging each child's capacity to function effectively with peers and the adult world with the ordinary rules, constraints, freedoms, and consequences children experience in their environments away from the center.

The therapist's role at Stage IV is that of group leader and counselor, reflecting reality and guiding the group as it plans its own activities and determines its own expectations, rules, procedures, and consequences. The therapist projects reality for the group to consider, suggests experiences, and assists the group in utilizing the abilities of each member.

The goals for each curriculum area of Stage IV are:

Behavior: to contribute individual effort to group success

Communication: to use words to express awareness of relationships between feelings and behavior, in self and others

Socialization: to participate spontaneously and successfully as a group member

Academics: to successfully use signs and symbols in formalized school work and in group experiences

While Stage IV emphasizes normal behavioral expectations, there are a number of opportunities for the therapist to come to the aid of a particular child who is just beginning to move toward these goals. The Life Space Interview developed by

Fritz Redl and extended by Nicholas Long and Ruth Newman is used extensively to assist a child toward greater self-direction as an outgrowth of a crisis. As a group leader, the therapist has responsibility to reflect for the group members the reality they face both at the center and away.

The center experiences planned for children at Stage IV are developed by the children themselves through group planning and discussion. The therapist helps them generalize from these experiences to school and home situations. Field trips and role playing are effective means by which the children try on new behaviors in supportive, pre-planned and real-life ways. Games and activities have elements of normal competition and game rules are not modified. Through these experiences, each child is helped to bring his own impulsivity and behavior under greater inner control. He is encouraged to be supportive of others as well as to accept support. With a greater awareness of cause and effect of behavior, in himself and others, and with acceptance of himself by his group, the child at Stage IV is able to tolerate greater stresses away from the center and is able to problem solve with greater maturity and insight.

As this emotional maturity begins to emerge, children at Stage IV often exhibit an eager, openness for assistance in academic work. Regular tutorial and remedial work is pursued with new meaning. The openness to accept actual academic difficulties and the determination to overcome them emerge as characteristic of this stage. Group learning, using ordinary school materials and texts used in a regular school are preferred. Often children use the study time at the center to review class work from school or to get help with homework.

Groups at Stage IV generally meet two or three times per week for approximately an hour to an hour and one half. Often these groups can be scheduled after their regular school hours. Recreation, art, music, and role playing should be available for them as they plan their time schedule and select their group activities.

As the group moves solidly into mastery of Stage IV objectives, it is essential to keep an orientation towards success in places away from the center. This stage begins the separation process, where each member of the group is seen as having more important and rewarding experiences away from the center. Often the child himself will let the therapist know of his readiness to terminate by statements that he doesn't think he needs to come back anymore. On such occasions, the child and therapist have a private conference to explore the realities of possible termination and to discuss a plan for intermittent support in the school, should it be indicated.

Stage V: Applying Individual and Group Skills in New Situations

Few children are kept at the center for this final stage of therapy. Each of the stated objectives is more adequately accomplished in a normal school setting and at home,and children at this stage are classified as "provisionally terminated". It is essential, however, that parents and teachers understand the therapeutic goal in each curriculum area at this stage of therapy. Support of the child independently from the center and therapist depends upon the understanding of the goals on the part of the people in the child's normal environment. With a responsible, normal, school environment the child will need nothing more from the therapist than a periodic visit to the child's home and regular preschool or school program. Extensive consultation between the school staff, parents, and the therapist may be needed initially. Effective support probably can be maintained through once a month consultation.

The therapist's role during this stage of therapy is primarily that of the child's friend and teacher. Clinical techniques are not used. The therapist uses the teacher role when visiting the regular school and home. By functioning also as a consultant, the therapist helps the school formulate translations of the therapeutic objectives for Stage V of the Developmental Therapy curriculum into suitable practices. General goals and objectives of Developmental Therapy at this stage are used to help the school focus on individual strengths and abilities and to plan ways to continue remediation in areas of deficit.

The regular teacher should be advised to anticipate occasional flareups. She should not attempt to modify routine nor provide a method of management which might isolate or set the child apart. Within the standards of behavior and participation set for the normal group, the teacher should be encouraged to hold the same expectations. If the preceding stages of therapy have been successful, the child no longer should be perceived as an emotionally or behaviorally disturbed child.

At Stage V, general therapeutic goals for each area of the curriculum are:

Behavior: to respond to critical life experiences with adaptive/constructive behavior

Communication: to use words to establish and enrich relationships

Socialization: to initiate and maintain effective peer group relationships independently

Academics:	to successfully use signs and symbols for formalized school experiences and personal enrichment

Successful adjustment to this stage of therapy will depend upon several factors: (a) the child's mastery of therapeutic goals at previous stages of therapy; (b) the previous adjustment of the child to concomitant placement in a regular school program during the therapeutic process; (c) the education of the regular school staff to the Developmental Therapy goals and objectives; (d) the implementation of Developmental Therapy practices by parents during all stages of therapy.

Developmental Therapy
Representative Objectives

Description

The representative objectives of Developmental Therapy are 140 general statements outlining a series of sequential, developmental milestones stated as treatment objectives which, when mastered, provide for therapeutic growth and a foundation for normal development. These objectives are contained in the Appendix, Form 18.

Specific objectives are selected from among the representative objectives by the treatment team to delineate the central focus of treatment for each child during a given time period. These objectives are identified as "major focus objectives." At least one, and no more than four, major focus objectives are used for each of the four curriculum areas with each child during a five-week period. The objectives are selected sequentially with mastery of previous objectives being necessary before new objectives are initiated. This sequential progression provides direction for parents, teachers, and therapists for anticipating what will come next. It also is a general control against providing too much, too rapidly, for a child to assimilate.

By selecting representative objectives sequentially within each of the four curriculum areas, uneven patterns of development will be quite evident. That is, a child may be at different Developmental Therapy stages in Behavior, Communication, Socialization, and Academics. By identifying which objectives have been mastered and the point of intervention, the treatment team can provide a program which moves a child along a progression of experiences appropriate to each area and stage of development. The team also can identify lags which need particular, intensive attention in order to reduce marked discrepancies among the four areas.

Grouping Children By Objectives

By grouping children according to similar major focus objectives, class groups of similar developmental stages are formed. Each child is placed according to his modal developmental stage for the four curriculum areas. Particular stages determine specific tone, experiences, materials, and strategies to be used with the group. The major focus objectives for each child provide direction for individualizing the program for a class at a particular stage. Group planning is done by determining which objectives are of major focus for all children in the group.

Representative Objectives Rating Form (RORF)

A rating form, RORF, is used for the selection and recording of each of the 140 Developmental Therapy Representative Objectives. These objectives are contained in the Appendix as Form 18. The rating form (RORF) is included as Form 19. The RORF is completed for the first time within eight to ten contact days after the child has participated in the program. Fairly accurate assessment of a child's general Developmental Therapy stages in each of the four curriculum areas can be obtained from testing and interview information during the intake process. However, specific ratings to determine major focus objectives prior to participation in a group do not always prove to be accurate at the time of testing as children often function quite differently in individual testing sessions and in a group. At sometime during the first eight days most children openly exhibit their individual responses and coping behaviors, and the initial RORF baseline is obtained. Generally, children placed in stages I and II show typical responses sooner than children placed in stages III and IV.

The RORF records developmental milestones already mastered and the treatment objectives for a five-week period for each child. At the end of each five-week treatment period each child is rated again by his treatment team.

The three members of the treatment team decide in concensus whether the child has achieved an objective , needs concentrated effort on an objective, needs continued support towards mastery of an objective , or is not yet ready to work on an objective. The entire list of objectives is completed in this manner. It is the responsibility of the lead teacher in each treatment team to make sure these RORFs are completed and handed in to the evaluation team on the determined date.

Symbols used to record this information on the RORF are:

✓ = The objective has been mastered. Nine out of ten times the child does this. Needs minimum reinforcement to retain behavior.

X = Major focus for current program. No more than four major focus objectives should be marked for each child in each curriculum area during any given treatment period. At least one major focus objective should be marked in each curriculum area.

R = A secondary objective which needs more work. The objective is almost mastered, but child needs continued support for complete mastery. Occasionally an objective may be marked R with the idea that it will never be a major focus objective. An R may follow an X or may preceed a ✓ but should not preceed an X.

NR = Not yet ready to begin work on an objective.

ALL DEVELOPMENTAL THERAPY REPRESENTATIVE OBJECTIVES SHOULD BE MARKED IN ONE OF THESE FOUR WAYS ON EACH RORF RATING.

No more than three or four major focus objectives should be marked in each curriculum area. There should be no blank spaces. Retrospectively, it is difficult to determine reasons for blank spaces, and such ommissions make evaluation data invalid.

To the extent applicable, each objective should be selected as a major focus in the sequence presented. If a team identifies several objectives needing treatment focus for a particular child, ordinarily the objectives would be selected IN THE ORDER IN WHICH THEY OCCUR on the rating form and would continue to be used as the major focus objective until mastered.*

Occasionally a point has arisen questioning whether or not a particular RORF rating accurately reflected a child's progress as evident to other staff members. When this has happened it was determined that the concensus rating had not been conducted as outlined. Either one member of the treatment team dominated the decision making or all members were not able to participate for one reason or another.

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*When objectives are marked for major focus OUT OF SEQUENCE raters are asked to let the evaluation team know why.

Periodic review of RORF rating procedures and annual review of the Developmental Therapy Representative Objectives for new staff members seems to help reduce such issues to a minimum. However, a simple procedure to further insure that RORF ratings are done by concensus is as follows:

1. The coordinator (director, or other individual responsible for the overall treatment program) reviews all RORF ratings at each five and ten week period.

2. For questionable ratings, the coordinator consults with the team in a "treatment meeting," reviewing all pertinent case material, illiciting contributions from each member of the team, and reviewing the questioned rating in light of the discussion.

3. When differences in opinion concerning ratings still exist, the coordinator and team plan actual situations in which the child can be observed in regard to the objective in question and a new concensus rating is obtained.

RORF Uses for Evaluation**

The RORF is used to indicate a child's initial developmental baseline, his current level of functioning, and changes over time.

**A complete description of the RORF and the evaluation system is presented in the paper: "An Evaluation System for a Psychoeducational Treatment Program for Emotionally Disturbed Children" in Educational Technology, 1973, by Huberty, C.J., Quirk, J.P., and Swan, W.W.

The RORF is completed at the middle (five week) and end (ten week) of each treatment period. The ten week rating provides major focus objectives for the beginning of the next ten week treatment period. It also helps determine any change in developmental stage for a possible new class placement. Children are regrouped according to RORF ratings at the end of each ten week period. No child is moved from one group to another without new RORF data.

The Rorf Summary

Every RORF rating is summarized on a RORF Summary Form for each child, showing ratings over time. The RORF Summary form is included in the Appendix as Form 20.

These summaries are located in the observation rooms adjacent to the classrooms and are used in an ongoing way by members of the treatment teams for (a) planning and monitoring a child's individual program within a group; and (b) conveying to parents, and teachers major focuses of the program and specific areas or objectives parents and teachers can focus on at home and school to assist the program.

In addition to ongoing uses, the RORF summary provides a visual, specific chart for reviewing and evaluating a child's progress in mastering each objective since the time of enrollment and in each subsequent five week period. Such information has proven invaluable in conveying to parents and staff the type and rate of progress a child has made toward a predicated termination point.

The Short RORF Summary

Another form of the RORF Summary is prepared at the end of each ten week period to record the percentage of objectives a child has mastered at each level of Developmental Therapy, in each curriculum area. This form, the *Short RORF Summary* Form 21 in the Appendix, is used to quantify progress in the treatment program and to answer the program evaluation question: "Is this child making progress in mastery of developmental milestones as outlined in the Developmental Therapy Representative Objectives?"

By using the percentage summaries of individual children, a description of group progress can be obtained also.

The SWAN

The *Systematic Who-to-Whom Analysis Notation (SWAN)* **(Swan, 1971)**, is an observational instrument composed of eight major and sixteen minor categories based on the representative objectives specified in Developmental Therapy. Each category measures some subset of the objectives and aims at mutual exclusiveness by encoding particular behavior in one, and only one, category. The system as a whole also aims at exhaustiveness, allowing every behavior to be encoded into some category.

The instrument measures a child's interaction in the center classroom with other children, the treatment team, and materials. Various behaviors measured by this instrument are judged to be positive, negative, or neutral. Increases or decreases in these behaviors can be assessed.

Observers are located in one-way vision observation rooms equipped with sound systems. The three-second rule is employed, i.e., one behavior is encoded in each three-second time period. Various protocol requirements are built into the system as described by Swan (1971). The data are encoded on the Who-To-Whom Observation Worksheet and provide for reporting information quickly and understandably.

Reliability investigations have yielded rather impressive findings. Inter-reliability coefficients range from .70 to .97.

All treatment teams are instructed in the use and interpretation of SWAN data. Weekly, at a debriefing session, the SWAN data are reviewed by the treatment team and program adjustments made as indicated.

The categories of the SWAN are defined in the Appendix, Form 22, including protocol rules for using the instrument. The Who-To-Whom Observation Sheet used by observers to gather data is Form 23. Forms 24 and 25 are summary sheets, used to report and summarize the observational data over time.

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Chapter Five

IMPLEMENTING THE TREATMENT MODEL

Diane Weller

The child treatment model at Rutland Center is organized to facilitate effective and expedient child treatment using Developmental Therapy. Children receive therapy in small groups at Rutland Center while continuing to participate in regular school or preschool programs. Major emphasis is placed upon continuous developmental growth in the four curriculum areas; Behavior, Communication, Socialization, and Academics. The curriculum presents a child with the opportunity to learn appropriate and success producing skills which build ego strength, self-confidence and more effective relationships with others.

Any child enrolled in a public or private school situation spends a significant amount of his day in that setting. The school is an excellent resource for helping emotionally disturbed or behavior disordered children. The school offers the child exposure to normal behavior, various learning opportunities, and various modes of self expression. Successful school experiences can reinforce a child's strengths and help to erase deficits. A cognizant and understanding teacher is an extremely effective resource to the center staff, helping disturbed children move toward better classroom adjustment and ability to respond to academic materials. Major emphasis in Rutland Center's treatment model is placed upon continuous support of children in public or private school settings while they are concurrently enrolled at the center.

Parent involvement in the therapeutic program will positively affect child growth in varying degrees. It is recognized also that children can be helped (strengthened) without parent cooperation and that some parents are unable to actively participate in a parent program for various reasons. Parent involvement, if carefully planned and embarked upon with sensitivity to the total situation, will result in sharing information between home and Rutland Center and continuous support for parents.

Organization of the Program Procedures

The Rutland Center treatment model is implemented by assignment of personnel to treatment teams. Treatment teams are assigned to work with groups of children, their parents, their school and any agency significantly involved with a child in their group.

Groups of children, or classes, are comprised of six to eight children. Stage IV classes may be larger and some classes may contain fewer children. The major reason for any decrease in class size is the need for constant individual intervention, often occurring at Stages I and II. Generally, all groups are of a number which allows every child to achieve success within the developmental curriculum.

Children enrolled in these groups are those accepted into the Rutland Center program at the time of staffing, or on an emergency basis. At the time of staffing, each accepted child is placed in a Developmental Therapy stage indicating that he has mastered objectives up to that stage. This information, in addition to a child's chronological age, the amount of intervention needed, and communication ability, is the basis for grouping children. Children are always grouped homogeneously according to Developmental Therapy stages , and have approximately the same chronological age.

Children accepted at staffing may be immediately enrolled in a Rutland Center class or wait to begin treatment during the next treatment period (quarter). There are three ten week treatment quarters; fall, winter, and spring, during the regular school year. In addition, a summer treatment period of six weeks duration is offered. Children may be enrolled in classes at the beginning of each quarter, or during the quarter, space permitting, up to the fifth week, or the third week of the summer quarter. Decisions as to particular class placement are made on the basis of RORF ratings* by those attending staffing, or by the Coordinator of Psychoeducational Services.

All classes are re-constituted at the end of every treatment period. Children are re-grouped according to developmental objectives accomplished within the Developmental Therapy curriculum as indicated by RORF ratings. Individual children can also be assigned to a different group if necessary, at any time during the treatment period.

Classes are conducted at the center either two, three, four, or five days weekly for the duration of the treatment period. The number of days which a group meets depends upon the Developmental Therapy stage of the class. Most children in therapy also attend a public school class or private school, kindergarten, or nursery. Classes at Rutland Center are planned to last from one to two hours, again depending upon the Developmental Therapy stage. The period affords enough time for effective therapy and for the child to profit from regular school experiences. If for any reason a child has been excluded from his regular school, a major goal of the treatment program is entrance into school at the earliest possible date.

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*The procedure for the RORF rating is included in Chapter Four and in the Appendix.

Transportation for children attending Rutland Center is provided by public school mini-buses or vans by arrangement with the system's transportation department. Parents and volunteers also transport children. The responsibility for making arrangements for transportation is shared by the Coordinator of Psychoeducational Services and the Rutland Center secretary.

Utilization of Treatment Personnel

The team approach has proven to be effective in increasing communication among center staff, and providing children with a support system which reaches many aspects of their lives. As well as having a positive effect on child treatment, the team approach allows for the assimilation of untrained or partially trained staff members, by placing them on teams with experienced therapists.

Program effectiveness is increased by the cohesiveness of the treatment team with other staff assigned for specialized services to the group and with the administrative staff. It is necessary for all staff to be informed as to procedures to follow when in contact with a specific child so that the child receives the same message from all persons with whom he comes in contact. Staff not on a child's current treatment team ordinarily do not become involved in a direct interaction with a child who may be in crisis or loose in the building, unless they have had previous contact with the child, know current objectives for him and are aware of management strategies being used by the treatment team. In any instance, these other staff members portray a friendly attitude which is consistent with the center objective that all adults at the center like children. Occasionally it may be appropriate for another staff member to step in the path of a child to block passage until the child's teacher can reach him. Usually however, other center activities continue as if it is assumed that the child will comply to expected rules. Noninvolvement is the rule, but a friendly, calm manner is essential.

Treatment teams are comprised of persons who work directly with children in classes at Rutland Center, with their public school teachers and principals, parents and any other significant persons or agencies involved with the child or family. A treatment team is made up of three persons whose roles or functions are direct outcomes of basic assumptions regarding child treatment. The three designated roles are those of lead teacher, support teacher, and monitor. These persons are assigned to work with a group of children for a ten week treatment period. Each staff person working full time in child treatment is assigned to two groups, one in the morning and one in the afternoon. Roles may change, and a staff person who is a lead teacher in one group may be the monitor for another group.

The following section describes the three roles of treatment team members (lead, support, monitor) and the additional responsibilities which they share in order to communicate with schools and involve parents as team captain or school liaison.

The Lead Teacher

The classroom responsibility of the lead teacher is to provide the central focus in the room, providing a fixed point of reference, a focal point. The children come to the lead teacher. Group movement is initiated by the lead teacher. The lead teacher allows for children to draw from his own ego strength if needed. The lead teacher usually focuses on the classroom activities and procedures, recognizes and encourages each individual to participate, including the support teacher, and meets the developmental needs of the children in suitable adult role activities.

The lead teacher is responsible for active planning for a particular group. This person is an experienced person in implementing Developmental Therapy and in using the RORF and SWAN data. The lead teacher is generally a Master's level person trained in the education of disturbed children. However a graduate student, social worker, or paraprofessional who already has received extensive training through observation and by working in the support teacher role may be lead teacher. This person plans classroom activities to help children reach Developmental Therapy goals and in the class uses various therapeutic techniques to help children move through these activities and achieve success in reaching goals. The lead teacher of a group is constantly and actively involved in therapy, assessing each child's readiness for change and constantly adjusting her techniques and activities to allow for maximum child growth.

The Support Teacher

The support teacher works as a compliment to the lead teacher's activities and is responsible for bringing individual children into the group process and back to the lead teacher's activity. No classroom can function well without a good support teacher. By conveying to the group that what the lead teacher is saying or doing is very exciting or important, the support teacher conveys backup and close adult team work. Subtle movements, redirecting back to the group, anticipating behavior before it occurs, and handling individual crisis are the major activities of the support teacher. When a support teacher is functioning effectively, the lead teacher should not be distracted away from continuing the group process when an individual child is not participating.

The support teacher may be a person experienced in Developmental Therapy or a paraprofessional, graduate intern, parent, or volunteer in training. He is, with the lead teacher and monitor, responsible for complete knowledge of the developmental curriculum and goals for children enrolled in the group. The support teacher shares in program planning with the lead teacher and is actively involved in the classroom. A major responsibility is the use of various techniques for "reading" individual behavior and in maintaining children's attention toward the lead teacher or the activity being presented in the classroom. In Stage IV groups, the support teacher must be adept at Life Space Interviewing techniques and must be able to take over the role of lead teacher should that person leave the room to conduct the interview. The support teacher is also responsible for the maintenance of the classroom and for preparation of appropriate materials.

The Monitor

The monitor is always a person experienced in the Developmental Therapy curriculum. The major responsibility of the monitor is to plan, arrange, and carry out all parent contacts, involving the parent of each child in the group to the extent recommended at staffing. The monitor is an adept and experienced parent worker usually with social case work training. The monitor's major functions are carried on outside the classroom with parents, usually through observation and conferencing either at Rutland Center or in the home.

The monitor observes the class regularly through an observation mirror and assists in daily program planning with the team. By watching the class, the monitor can provide information of value to the team in making necessary adjustments for individual children or for the group. Particularly important topics to look for are:

Group:
1. Look for the general trends in class functioning, examples: transitions, group tone, group structure, interactions, timing, length of activities.
2. Consider appropriateness of materials, physical environment, and activities for the stage of Developmental Therapy for the group, in each curriculum area.

Child:
1. Determine the relationship of each activity to the specific Developmental Therapy Objectives for each child.
2. Consider how the child and group needs are blended.

Teacher:
1. Are the types and quality of team verbalizations appropriate for the desired results?
2. Consider type and quality of physical interaction between teacher and child.
3. Look for creative and responsive listening.
4. Consider the emotional and reaction of teacher to individual child.
5. Note the teacher's role for the particular stage of therapy.
6. Watch for consistency and appropriateness of individual and group limits, rules, and procedures.

The Team Captain

One member of the team is assigned as the team captain, responsible for assuring that the developmental curriculum maximizes its effect upon each child, by making sure that each team member carries out his or her responsibilities. This person leads debriefing sessions, held daily after class, and any other team meetings. During debriefing sessions relevant aspects of the day's classroom experience are discussed as well as recent developments in a child's home or school. The team captain also leads discussions of material derived from the collection of observational data. Any information discussed at debriefing is for the purpose of internally evaluating each child's progress and making decisions by concensus regarding child treatment.

School Liaison

An experienced member of the team is assigned as the school liaison person to arrange and conduct contacts with public and/or private school personnel. This may involve conferences, observation, or direct contact with children, either at school or at Rutland Center. Decisions regarding specific recommendations for school contacts are made jointly by the team during debriefing sessions. This team member is responsible for communicating information from Rutland Center to the public school and keeping channels of communication open by being supportive, arranging weekly contacts with the school, and being available for crisis intervention at the school. Because of the time involved in arranging and conducting school liaison activities, more than one person on the team may be assigned to function in this capacity.

New Staff

All new staff receive orientation and training in Developmental Therapy through the staff training program, observation, participation in debriefing sessions, staffings, and other center meetings. After these experiences, they are assigned to treatment teams as support or crisis teachers, or observers and are closely supervised in their contacts with children, teachers, and parents for up to two treatment periods (20 weeks).

Specialized Programs

Other persons, though not placed upon teams, work directly with groups of children, such as the music therapist, art therapist, recreation leader, reading specialist, crisis teacher and speech therapist. These persons arrange their schedules with the team captain; and plan activities which are directly related to the same Developmental Therapy goals being used by the treatment team. They must participate regularly in debriefing sessions and collect and arrange their own materials.

Music, art, and recreational personnel work with groups of children primarily in Stages III and IV, occasionally in Stage II. The reading specialist and speech therapist may be assigned small groups of children in Stages II, III, or IV.

When any specialized person, such as a music therapist enters a classroom for the purpose of therapy, he or she assumes the role of the lead teacher in the group for the duration of the experience which has been planned. The change in roles necessitates having the support teacher leave the classroom, and the regular lead teacher assuming temporarily the support role. The lead teacher is then able to provide consistency and support for the group through her presence and knowledge of the Developmental Therapy goals and therapeutic techniques. When the music therapist leaves the room, the support teacher re-enters. Recreation leaders, art therapists, music therapists, reading specialists and speech therapists function in the same manner, by entering the child's classroom and presenting their lesson in the child's environment.

The recreation person has an added responsibility to attract and hold attention by motivating activities outside. Yard limits are much harder to establish and maintain than inside limits. There should be a few simple but clearly defined boundaries, procedures and rules for outside activities. When a group is having recreation with the recreation leader, that person is the lead teacher and either the regular lead teacher or the support teacher assumes the support teacher role for the recreation team.

The Crisis Teacher

Crisis teachers function at Stages II and III and are assigned to one or more groups in order to provide maximum support to children needing constant intervention. The crisis teacher is available to enter classes in need of assistance as a third classroom teacher or to replace a teacher leaving the class with a particular child. The crisis teacher does not remove children from a class. The crisis teacher is responsible for acquainting him or herself with therapy goals for individual children and for strictly adhering to the role and limits prescribed for him in a given group.

Bus Drivers

Rutland Center bus drivers play an important role in the child's associations between school and center. The drivers are expected to be acquainted with behavior management precepts and sensitive to children's individual needs. Bus drivers are responsible for the safety of all children on their bus and orderly conduct. They are required to attend specified treatment meetings and may be included in program planning or debriefing sessions. Behavior problems on busses are reported by the driver directly to the Coordinator of Psychoeducational Services. However, treatment teams communicating easily with the drivers gain invaluable insight into their children in other situations.

Treatment Planning Procedures

A variety of procedures are utilized by treatment teams in order to maximize the effects of child treatment. Among these are the daily debriefing sessions, use of evaluation data, consultation by specialists, treatment meetings, and weekly staff meetings.

Debriefing sessions are held daily and attended by all persons who have worked with a group or will work with the group during the treatment perod. As a rule, debriefing sessions should consider:

1) What came up in the therapy class that day; how teachers and children reacted, and what changes are indicated for intervention strategies and materials.
2) What has come up in the weekly school contact and what should be conveyed to the regular teacher from the center program.
3) What has come up in the weekly parent contact; what should be conveyed to parents at the next contact.

Consultation to the treatment teams regarding specific problems is available from the psychiatrist, psychoeducational coordinator, evaluation personnel, pediatrician, and other specialists. These persons usually observe a class or child upon request through the Coordinator of Psychoeducational Services, and provide input to treatment teams by participating in the daily debriefing. Other specialized services or information, such as a referral to the Crippled Children's Program, or speech and hearing evaluation can be arranged either by the team captain, monitor or the Coordinator of Psychoeducational Services. Such contacts are recorded on the School or Agency Contact Card.*

Treatment meetings are special sessions requested by the team captain to the Coordinator of Psychoeducational Services. Purposes of such meetings are; adjustment of individual goals or programs, discussion of intervention strategy, arrangement of outside supportive services, and consideration of termination of treatment. These meetings may be held during the time allocated for class debriefing or at another time. All team members and persons having input regarding the particular child are required to attend these meetings. The team captain is responsible for insuring that all persons attend and for presenting material at the meeting. He or she also brings the child's permanent and treatment folders to the meeting and takes written notes on the proceedings. These notes are then written and given to the Coordinator of Psychoeducational Services for review, are finally typed and placed in the child's permanent folder, and filed.

Treatment Outcomes

At the end of each treatment quarter there are several possible outcomes for both children and parents. The major decision made at or near the end of each quarter is whether to maintain a child in treatment or terminate him from the program.

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*The School or Agency Contact Card is described in Chapter Six and contained in the Appendix.

Children who are to remain in treatment are eligible for re-grouping according to the levels of developmental therapy objectives which have been achieved. A general meeting is called by the Coordinator of Psychoeducational Services for the purpose of obtaining treatment teams' recommendations for future placement of children, school liaison procedures, and changes in parent involvement. This meeting is held during the last week of each treatment quarter. The Coordinator of Psychoeducational Services formulates a schedule of groups of children for the next treatment period and assigns treatment teams to work with them. Treatment personnel are generally assigned to work with different children every ten weeks.

Termination from treatment is the other major outcome of therapy. The following procedures must be completed in sequence in order for a child to be terminated from treatment.

1. Names of children who are possible candidates for termination are submitted to the Coordinator of Psychoeducational Services during the seventh week of the treatment period. All treatment team members agree that this child may possibly be terminated.

2. The Coordinator establishes a date and time for a treatment meeting for each child whose name has been submitted. These meetings are held during the ninth week of the treatment quarter.

3. The school liaison person contacts the child's teacher in order to gather information regarding the child's growth and adjustment, and her general perception of the child and ability to help him.

4. The monitor or parent worker contacts the child's parents for the purpose of gathering information concerning the child's progress and adjustment at home, and the parents' perception of his or her problems.

5. The treatment team completes the end of quarter Representative Objective Rating Form (RORF); and assess the child's growth and ability to maintain learned skills.

6. The scheduled treatment meeting is held, with information being presented from the home, school, and treatment program. The decision for termination is reached if all are in agreement that the child has progressed sufficiently and will be able to maintain his progress. If the child is not to be terminated, he will be re-enrolled in a center class.

7. End of quarter, 10th week conferences, are scheduled with both the school and parents. At this time the recommendation for termination is discussed. If for any reason it is not agreed upon by a child's parents or teachers, the child may be re-enrolled in the treatment program. If termination is agreed upon, the parents and teacher are asked to fill out the Referral Form Check List (RFCL), the problem check list which was completed by the parents and the child's teacher at the time of referral.

8. A member of the Rutland Center treatment team discusses termination with the child. He points out realistic growth and strengths and plans the next step with the child.

9. The child and his parents enter the tracking phase of the Rutland Center Program. He is considered to be provisionally terminated from treatment and a Termination Card is completed. (Form 26 in the Appendix).

Tracking

Tracking children terminated from treatment refers to the periodic contacts of a supportive and evaluative nature, which a child, his parents, and his teachers, receive from Rutland Center personnel. Every child is tracked (or contacted) by his last lead teacher and every parent is tracked by his last monitor. Tracking begins immediately after termination. The amount of support and intervention given during the tracking phase is decided upon at the end of quarter conferences and termination treatment meeting. The tracking phase lasts twelve months, with the most intervention occurring early in this phase. A child and/or his teacher might initially be contacted twice each week. This intervention would decrease to a once per month contact by the end of the second month, and be maintained at this level for the remainder of the tracking phase. Parent tracking contacts might be less frequent, although many parents continue in regularly planned parent programs at the center after their child has been terminated. At the end of the twelve month period, another RFCL is obtained from the child's teacher or teachers and parents. At this time the child is permanently terminated from treatment.

If for any reason a child adjusts unsatisfactorily to provisional termination or regresses for a detrimental period of time at school or home, he will be reinrolled in treatment at the center. If his adjustment remains satisfactory, he and his parents and teachers will receive services after permanent termination only upon their request.

Chapter Six

LIAISON AND FIELD SERVICES

Bonnie Lee Mailey

School Followthrough for Children Enrolled at Rutland Center

The major goal of the school followthrough program is to strengthen relationship between the child's public school teacher and his Rutland Center team, by improving communication so that both environments can reinforce the progress of the child.

Specific objectives for accomplishing this general goal are:

1. To make weekly contact with the child's regular school to exchange information about the child's current adjustment in both places, center and school.
2. To provide an emergency or crisis resource to the child's regular school by being available for consultation, by telephone or by contact, on an emergency basis.
3. To establish linkage for the child between his center program and his regular school program by having his center teacher visit him in his regular program.
4. To provide assistance to the child's regular teacher by encouraging observations of the child's program at the center and by sharing Developmental Therapy treatment objectives (RORF ratings) and techniques.

5. To provide intermittent support to the child and his regular school during the period of "provisional termination" (also called "Tracking").

With close linkage, the center program should not be isolated from the child's daily school life, and carryover should be greatly enhanced from the center class to the regular classroom.

The major effort should be that of sharing. Each agency should view the other as a component of the total life style of the child. If approached in this way, good working relationships can be established, communication facilitated, and the sharing of progress and problems becomes a team effort. The treatment team needs school information to incorporate into the therapy program. At the same time the school profits by getting consultation and guidelines for assisting the child at school, as well as support in managing problem behavior. Both teachers benefit from insights, view-points and experiences of the other. Only in this way can two differing environments link and become cohesive and meaningful to the child.

School followthrough for children enrolled at the center begins in the second week of each treatment period. By the end of the third week all teachers of school age and preschool children should be contacted. Subsequent contacts depend upon many factors but a visit to the school once a week is recommended.

After the first visit, which should be a conference, the treatment team member assigned to school liaison, in planning with the field center county consultant, determines whether the visit would be more useful as an observation of the child while in his regular class or as a conference with the teacher. Occasionally the visit may include a contact with the child. In any instance, the first visit is always arranged with the Rutland Center county consultant and the child's school principal. It is desirable to meet with the principal so that he can be informed of the nature of the school followthrough and can be included to the extent of his availability and willingness. A supportive, involved principal can contribute immeasureably to the success of the school followthrough program. Each principal will have a particular procedure for visitors to his building.

School followthrough is the responsibility of the lead teacher in the treatment team ordinarily. In counties served by a field center, the Rutland Center county consultant has overall responsibility for the school followthrough contacts for all county children attending either the Rutland Center or the field center. Often the county consultant will arrange for the child's regular teacher and the treatment team school liaison person to meet initially. In other instances the county consultant will serve as an intermediary for all school contacts. Because each county consultant is Rutland Center's permanent representative in a particular county it is possible for school followthrough procedures to be worked out to suit each particular county.

Sensitivity to the regular classroom teacher's situation and awareness of her general views of the center have been major factors in ultimately meeting center objectives for school followthrough. In particular, awareness of the following situations has proven to be of help.

1. The regular classroom teacher has a LARGE number of children, with a large number of demands for her attention, leadership and support. The center's small treatment groups look insignificant to a teacher with "thirty problem children" in her room for six continuous hours each day.

2. The regular classroom teacher has limited special services and resources to back her up, particularly when a disturbed child is in crisis, out of control or demanding her entire attention.

3. Some teachers have expectations that the center should serve all children identified and referred. Often they expect immediate and dramatic improvement, and are highly critical of center services which they perceive as inefficient and slow. Transportation schedules are most often criticized.

4. Some teachers are hostile toward outside, professional practices and look for errors and contradictions to support their views. In particular, such teachers often criticize the child's schedule at the center as interfering with their classroom program. They also tend to be critical of a recommendation for provisional termination.

5. Many teachers are very effectively dealing with disturbed children in their classes and only need the assurance and support that they are handling problems in the best way for the given situation. Providing support and a means to ventilate frustrations may be all that is needed.

6. School staff may view Rutland Center staff in a way different than they actually are working. It is important that the school staff understand responsibilities and roles of various center staff with whom they may come in contact and to view the center program as a supplement to their own school program for a child.

7. Awareness by the center staff of the influence teachers' characteristics have on the problems and subsequent adjustment of a child is particularly important to effective school followthrough. Among significant characteristics the center staff have identified are the following:

   Positive Teacher Characteristics

   Creative, adaptive
   Energetic, vivacious (but not overwhelming)
   Flexible
   Perceptive of child's needs, interests
   Accepting of child apart from behavior or problem
   Consistant in approach
   Open to suggestions, new ideas, change
   Ability to implement suggestions
   Child oriented
   Ability to use positive reinforcement appropriately
   Faith in child's ability to grow
   Recognizes own strengths and weaknesses
   Ability to separate own needs from those of child
   Ability to objectively assess the on-going program,
   Ability to change as child grows.

   Negative Teacher Characteristics

   Combative
   Personal
   Inconsistant
   Defeatist attitude; Guilty
   Rationalization of mistakes
   Compulsive

Seductive
Provocative
Defensive
Threatened
Over reacting
Intolerant

Projecting
Autocratic
High strung
Over control of self
Lethargic

Conducting A School Followthrough Conference

Be sensitive to tone of the conference and manner of approach. Comments made to the child's regular teacher are not just pleasant conversation but come from a preplanned structure of ideas and principles to be communicated. The manner in which these messages are relayed, the timing of these comments during the conference, any repeated comments for reiteration, and the entire direction of the conversation should be meaningful and purposeful. Some messages originally planned for inclusion may be omitted, whereas some unexpected incidents or changes might produce a new emphasis.

Have specific major focus objectives noted from the four curriculum areas. It is important that these goals are clear to the classroom teacher; however, you may be working with some goals in the center while focus on a particular goal in the regular classroom may be premature. Even if working on the same goal, the procedures used in school (worked out between you and regular teacher) may vary from procedures used in the center. In any event these differences should be discussed and made clear: Is the management different? Should it be? Is the goal realistic for the regular teacher? The number of specific objectives worked on in the school generally is less than the number worked on at the center. New goals to be worked on at school should be related to problems arising in the school, but developed around developmental objectives.

Remember the treatment program discussions at staffings and the stages of development for the child. Know thoroughly: a) observable behavior; b) possible underlying meanings behind behavior; c) child's stages of Behavior, Socialization, Communication, and Academic skills; d) the child's perception of his problem, of his school life, center life and home life; and e) what changes his teacher may expect as he moves through each stage of therapy and each objective. Children often operate at different developmental stages in different settings. Be sure to explore this possibility with the teacher. Be ready with detailed information about the child in the center program but don't consider yourself as the advisor to the teacher or major source of advice. Try to understand how the teacher perceives you (this varies from teacher to teacher and school to school).

Even when teachers make you feel comfortable and are eagerly asking questions, be cautious. First get their ideas. From what they discuss, try to determine a) what they did that worked and b) what are still problems to them. Work together on a procedure they can be comfortable working with.

Map out the road ahead in a realistic way, but be positive. With many disturbed and behavior problem children, regression should be expected. Encourage a teacher to see progress even during periods when child slips back. When carryover is slow, don't doubt the classroom teacher's technique or ask, "What went wrong?". Let teachers know that we can't expect miracles overnight and every small step forward is significant toward a long range goal. Be positive and confident of procedures you suggest. Often teachers get discouraged and say a technique won't work. Explore with them reasons why it might not have worked. Your confidence should be realistic. Explore also examples of improvement as they happen in the group.

Be cautious in giving out clinical information from staffing (home details, etc.). This is confidential information. Learn to phrase main needs, concerns, and recommendations in appropriate terms. Example: rather than say, "Charles has strong repressed hostility towards his teacher," you may say, "It means a great deal to Charles to feel accepted by adults - for instance, to know he is liked by you. His teacher is important to him." Another example: rather than say, "Tests indicate Sam really hates his father because his parents are divorced," a more positive remark, "Sam feels the loss of his father. A man recreation director could serve a very meaningful role in his school program." When caught off guard regarding some detail of home or school it is best to say nothing than say too much.

You may hear things about other center staff members, or other teachers. Don't over react. Even if you personally feel that the reported situation is not appropriate, use tact in your response so that things don't grow out of proportion. If you hear criticism about a co-worker relay it only when you feel it is something that person would like to know and would grow from. None of us are beyond constructive criticism. However, relay of trite or petty information can easily sound one sided, accusative, or ridiculing while constructive criticism can be of benefit to all.

Get to know your principals and how they would like each visit conducted. Intermittently he may wish to have conferences with you regarding a child and the child's classroom teacher. Take cues from him. Get to know the school secretary, also be friendly. Always let her know when you enter and leave the school. When leaving, try to arrange for the next visit.

This reduces amount of phone calling and gives a continuity to school followthrough.

When You Meet With Anger, Negativism, Coolness

When a teacher first realizes you are not there to take away her problem she may be hostile or perplexed. She then learns that she not only is expected to keep the child in her class but work along with the center during the period of treatment. The manner in which you relay this information will make the difference as to whether she will cooperate or not. If she begins to try out suggested procedures she will need frequent reinforcement. You must stay-in-there with her and support the school effort with frequent contacts.

A defensive teacher may feel you are observing her critically even though your words are "flowery". When observing (if you do) pick out specific realistic things to support her with even if the rest of the session seemed chaotic.

Some teachers may continue to make negative remarks regarding what the child reports that he does at Rutland Center such as, "All we do is play." Communication is essential so that the teacher understands, in detail, the child's program at the center.

If negative management techniques come out in the initial contact, don't react while you are establishing relationships. On the other hand, don't indicate it is great! The best response is to indicate that you are accumulating information. Respond, "..and how does he react to that?". Don't be too quick to begin getting things straightened out. Let the teacher talk it out. Sometimes this is all that she really wants. Use your intuition from there. It may be best to wait until another time to develop a detailed plan of change. Take your cues from her. After initial blow off some teachers are eager for a plan of action. Other teachers just have a loud bark anyway. Be careful not to pull back or be defensive. There is often a predictable response pattern with teachers and usually after initial testing, your accepting and consistant response is what they really hope to see in you as a professional consultant. If they see you as "solid" they really want to join the team, although some can't afford to show it. When time comes to try to change ineffective techniques you should be in a stage in relationship where the teacher has talked out the problem, and is waiting and/or asking for reaction, advice or response. Never move in to begin this until you feel this coming from the teacher.

At times one teacher will become critical of another teacher of the same child. This may be done openly or with smooth indirectness. Focus back on the child. How does he respond? Does his behavior vary under different conditions? What conditions elicit the most desirable behavior? What could be done to create more of these conditions? Look for positive elements which tie in to the child's developmental objectives. With two or more teachers, you may be in a situation where teachers try to get at each other by asking you direct questions as to management. Example: "Is it good to make Johnny miss creative art when the entire class is participating?" or, "Is it good that Helen has to take notes home to her mother? She always gets a spanking." "Should you jerk a child bodily into line?" A teacher may be telling you techniques used by another teacher sitting next to you! The county consultant usually can steer you through these situations until you are familiar with the teachers and staff of each child.

Remember that a negative, defensive teacher is a perplexed teacher who is usually involved emotionally with the problem and has usually tried everything, but no one thing long enough.

Let her talk (but take mental notes; you can use her words later)

Reflect her feelings.

Cut through all the verbal intanglement of frustration with a beginning suggestion; give her one thing to try tomorrow, then follow-up the next day.

Encourage her to "hang in there"; no harm (in some cases) to admit there are days you would give up too.

Let the teacher know a miracle won't happen and certainly not overnight; but with home, school, and center working together improvement will come.

Don't let a teacher get carried away with too many problems she is trying to change at once; it is best if you work on one until progress is made.

Questions to Consider During and After A Teacher Contact

1. What is the teacher's general attitude towards this child? Are any positive comments made spontaneously as problems are related?
2. Do you have to ask this teacher to tell you what the child's strengths are? If so, what is her response?
3. Does the teacher seem uneasy about being questioned or asked to discuss the child? If she seems reluctant, why?
4. Does the teacher seem overly eager to blame the child for classroom problems? Has she rated him on the RFCL, primarily with 1's and 2's?
5. What seems to be the purpose for referral? Would she respond to consultation and follow-up, or does she seem anxious to be rid of the child?
6. Is this teacher too personally caught up in the child's problems: Does she mention all the things she has "done for" this child? Does she dwell at length on heartbreaking incidences in child's background or does she relate information matter-of-factly and leave interpretations to you?
7. Does she seem consistant? Does she indicate that she has "tried everything and nothing works"? Does she indicate she at times gives in to manipulation?

8. Is the classroom atmosphere warm, accepting but structured; or rigid and demanding; or is structure absent altogether?

9. How might the child view this teacher: Warm, responsive, but "workable"? Nervous and highstrung? Cool, detached and autocratic? Would he have to work for approval and acceptance?

10. How flexible is the teacher: Does she seem sensitive and responsive to individual differences in a group? If so, is she able to respond to these needs comfortably, or would she tend to resent the child or see any adaptation on her part as an inconvenience? Does she seem "set" on one method or approach only?

11. How does this teacher respond to aggression? Does she over-react, or get emotional and trigger more emotional reactions from the child and the group? Does she imply that the child does these things to get at her?

12. Is the teacher able to see cause and consequences in problem situations? Can she give you precipitating incidences that caused the child's reaction, or does she seem unsure about why and explains that he always causes disturbances.

13. Are the teacher's interactions with the child almost always concerned with a behavior problem so that the group as well as she come to view the child as negative, or even reject him? Does she relate that others come and tell her about this child's behavior?

14. Does the teacher indicate that she ever talks with the child to get his perception and feelings about any situation? Or does she seem to automatically blame him?

15. Would this teacher be able to constructively handle the group in any crisis situation with any one child?

16. Would the teacher be able to turn the negative into a positive experience for the child and group, or does she accentuate the negative? Can she use praise effectively?

17. Does this teacher seem aware that preventive measures are often helpful?

18. Is the teacher spontaneous? Can she use humor constructively?

19. How verbal is this teacher with feelings and group tone? Would comments and conversations always be focused on academics and instruction? Would behavioral issues always be viewed as right-wrong?

20. Would children in her class be motivated to come to school each day? Are they invested in their class and group?

The Crisis Call

On a crisis call, however strongly a child is reported to be "out of control" or in similar distress, respond supportively to the school that they did well to call you; that they helped by staying calm throughout; and that planning with them for management strategies (after the initial blow in the school) is what you are there for. Provide interim suggestions for managing the crisis, if indicated. Often, after an initial release of anxiety, the teacher will begin to see at least temporary solutions herself. It is usually desirable for the teacher and principal to manage the crisis if the outcome is to be generally beneficial to the child. In a few instances, where a center team member has had on-going contact with the child and the school, it may be advisable to make an emergency visit to the school. This would be particularly true when the school staff feel unable to cope with the child. Another alternative would be to call the county consultant for a crisis visit to the school. In a few instances, when the school liaison team member has a conflicting schedule, another treatment team member might make the crisis visit. All crisis calls and visits should be followed up within the week by a conference with the teacher, to plan constructive strategies to help the child and school reduce the likelihood of a repeat crisis.

Encourage an open line between you and the teacher of the child. Relay information as frequently as the teacher indicates she wants it. DO NOT MAKE CALLS TO SCHOOLS AND RELAY INFORMATION TO ANY OTHER PERSON IN THE SCHOOL (unless it is to have the teacher call you). When you and the teacher have a good working relationship in the school and she is beginning to implement a followthrough program, work toward having her visit the center for observation with you.

When Returning From A School Contact

The success of the school followthrough aspect of the treatment program depends upon the effectiveness of the communication between school and center. Report the results of each school contact to the treatment team at the daily debriefing. Obtain from the team information or new program directions to be conveyed to the school; and convey to the team ways that the child can be helped at the center to be more successful at school.

Evaluation

Each school contact, conducted either at the school or center, is recorded on a *School or Agency Contact Card.* This card is contained in the Appendix as Form 27; with the *Guidelines for Use of Rutland Center School or Agency Contact Card,* Form 28. Data from this card are used to evaluate the extent to which the five school followthrough objectives are being met. The information on this card also provides a record of all past school contacts regarding a child.

Another form of evaluating the School followthrough Program is by annually requesting classroom teachers and principals to complete questionnaires regarding the effectiveness of the service. Responses from these questionnaires are summarized and used to modify and improve services. Included in the Appendix, Forms 29,30, and 31, are the *Classroom Teacher Questionnaire*, the *Principal Questionnaire*, and a *Sample Cover Letter*.

Chapter Seven

RUTLAND CENTER
SERVICES TO PARENTS*

Mary Margaret Wood

The overall goal of the Service-to-Parents component of Rutland Center is as follows:

> To provide information to parents about the needs of referred children and assistance to parents in meeting these needs through their involvement in various center programs and services.

This goal is broken down into four specific outcome objectives:

1. To encourage parents and staff to share information concerning the child's needs and developmental progress in behavior, communication, socialization, and academics during the period of the child's treatment, at home and center.

2. To encourage parents involvement with the center to the extent recommended at staffing and at ten week intervals during the period of the child's treatment.

3. To stimulate parents' interest in the child's growth and development so that during the second, and subsequent ten week treatment periods they will develop various appropriate activities and procedures to use with their children at home.

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* Significant contributions to this program have been made by Laura K. Levine A.C.S.W. and David L. Levine, Ph.D. as Coordinator of Rutland Center Social Services and Consultant to Social Services, respectively. Both Mrs. Levine and Dr. Levine hold faculty appointments at the University of Georgia, Graduate School of Social Work.

4. To provide crisis help and assistance to parents at their request, obtaining supportive help for family and personal needs from other community resources.

The key words of the overall goal, "provide information about ....needs" and "assistance ....in meeting these needs," imply the essential commitment of Rutland Center to parent involvement. Children can be taught to behave successfully in numerous controlled clinical settings; however, the test of the effectiveness of a child's program comes when that child is at home or at school. In order to attain lasting results for the child, the people he lives with, parents or parent figures, must assist the child in generalizing the successful behavior he experiences in the center setting to his real world. This implies involvement of parent in understanding the needs of the child and assisting the center staff by implementing appropriate activities to meet the child's needs at home. To this end, parents are seen as a vital part of the center treatment program.

The present model for parent programs and services at Rutland Center is the product of two years of staff planning, trial implementation, evaluation and program readjustments. Certain concerns have influenced the program. In particular, clear parameters had to be established regarding the scope of the parent service. The decision was made early in program development that parent services would be centered primarily around the developmental needs of the children. The intent of the parent service then became primarily one of keeping parents and staff informed about the child's continuing development at home and center.

Rationale for limiting the scope of parents services came primarily from three sources.* First, the cost for a full, extensive program involving enhancement of parents' personal development, parent counseling, and training would considerably reduce the resources available for the children's service. Second, not all parents need extensive services in order to help the center help their child; their own interests, needs, and personal resources vary greatly. Third, limited parent services were successful during the first two years of center operation as measured by the successful termination of a majority of children served with little or no parent service.

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*The staff is indebted to the thoughtful review of the Service-to-Parents component by Dr. Samuel E. Rubin and Dr. Robert Lange. At the request of Rutland Center, these consultants reviewed the numerous options and procedures developed during the two years and have made a considerable contribution in support of a limited-but-effective effort.

Several assumptions about parents underlie the present form of the parent services.

1. Parents' understanding and involvement with their child tends to enhance the child's growth and development.
2. Parents' lack of understanding or involvement may not significantly work against the child's growth and development, particularly with parents of older children.
3. Parents' unique assets and problems will determine the amount and type of program or service they need and are able to use.
4. Parents' ability to participate will depend upon their own comfortableness with the staff and their confidence in the program for their child.
5. Parents can develop increased effectiveness with their children when they progress in positive feelings about themselves as parents, seeing for themselves positive changes in their child which they can attribute to specific parental skills they have developed.

Implicit in all of these assumptions is the need for the center staff to inform, to support, and to be accessible to parents. What is happening to the child and how it is effecting others in his family is the essential focus. Using a developmental reference from Developmental Therapy, parents and staff prepare, together, to respond to new patterns of behavior as they emerge in the child. When parents reach the point of involvement with the center that they can plan and implement appropriate and successful experiences for their children at home, the primary goal of Rutland Center's service-to-parents has been reached.

The Parent Programs

Providing for parent services is an integral part of center planning for each child and his family. The treatment team working directly with a child is responsible also for developing a program with the parents which best helps the parents become involved with the center to the extent recommended at staffing or, later, at the 10th week conferences.

There are five specific programs for parents:

1. Parent Conferences: weekly appointments to discuss the child's progress at school, home, and center. These conferences can serve to facilitate the partnership aspect of the treatment program. Both the treatment team and the parents share information to the end that the child's development will be enhanced in both settings.

2. Parents' Auxiliary Association: an organization of Rutland Center parents which meets in the evening once a month at the center. All parents are welcome. This program offers parents an opportunity to meet and get to know other parents whose children are enrolled in the Rutland Center program. Information may be shared, programs to help the center may be planned and implemented, and the feeling of isolation which may be felt by the parents of an emotionally disturbed child may be reduced at these meetings. The group also is involved in a number of helping activities. Parents report that this is a significant way that they can reciprocate and "do something for the center".

3. Observation: learning about the Rutland Center program by observing the class through a two-way mirror with staff who are also working with the child. For many parents, observing may be their first opportunity to actually see their child interacting successfully in a group situation. Observation may be of help to a parent who wants to see a particular objective being implemented. Also, observation provides parents the opportunity to really know what is going on with their children at Rutland Center.

4. Home Program: the monitor and parents plan new management routines for parents to use at home. Often these planning sessions are conducted in the home. It is difficult for a staff person to understand the home situation of which parents speak until he actually sees the family members on their own ground. Parents may feel that the home contact is the best way to explain themselves. In this case, the Home Program may be chosen.

5. The Parent Training Program: parents learn the skills used by the Rutland Center staff by working as a support teacher with a treatment team at the center. The amount of time required will depend upon the parents' time and interest. This program carries the observation program a step farther. It can be very useful to the parent who

> feels the need to actually use Developmental Therapy techniques and wants to learn them in a monitored situation. The feedback on the parents' progress is then immediate.

These programs are chosen by the parents according to needs, interests, and the availability of their time. Often programs are combined. For instance, parent conferences and observations often are used jointly.

Implementing the Parent Program

Planning for parent participation begins with information gathered at the first intake conference and culminates at the time of staffing. At staffing the staff considers the parents' strengths, resources, problems, and limitations. The parents' readiness to participate, expectations for amount of involvement which is reasonable to expect, and explicit information about the parents' contributions to the child's development are considered also. From all available information, the staff recommends one of three levels of participation.

1. Minimal Participation: requiring
   * a) signed request for service,
   * b) participation in the Intake Conference,
   c) participation in the Parent Planning Conference, and
   d) participation in the 10th Week Conferences.

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*These activities are completed prior to the time a child is staffed.

2. Intermittent Participation: requiring
    a) all of the activities cited in Minimal Participation and
    b) occasional contact at center or home during a ten week treatment period (not including the 10th Week Conference); these contacts are initiated by the monitor but may be of a crisis, "walk-in", nature.

3. Extensive Participation: requiring
    a) all of the activities cited in Minimal Participation and
    b) once a week contact at center or home, either individually or in a group; these contacts are planned and scheduled in advance by the parents and monitor. Four or more broken appointments during a ten week treatment period would constitute "Intermittent Participation" even though weekly contacts had been agreed upon.

By this recommendation for an amount of participation, the monitor has a particular objective established to work toward.

The amount of parent participation is discussed again at the 10th Week Conference for the purpose of moving parents to an increased participation if appropriate.

Parent programs begin the second week of each quarter. Monitors in each treatment team make personal contact with each of the parents in the group, usually by telephone. To maintain close, personal touch, secretaries do not arrange for these appointments and letters are not used. It is important also to be sure parents know whom they are to meet, for what length of time, and the exact location. Often a previous monitor will be on hand to greet parents and introduce them to the new monitor if this had not occurredat the previous 10th week conference or at the Parent Planning Conference.*

How often a parent participates is recommended at staffing and discussed with the parent at the Parent Planning Conference.

Some parents will only be able to participate in minimal ways, particularly during the first ten week treatment period. Some parents will be having such problems at home that home planning and visiting will be essential. Other parents are ready for observation and others for learning Developmental Therapy skills by working in the support teacher role much as the volunteers do, learning while working. When parents elect to do this, the support teacher comes out of the classroom and the parent works in that position for a specified part of the day.

Parents do not always need to be seen individually. For example, a monitor may notice that several parents are confronted with similar problems and similar "major focus objectives". It might be very useful to schedule these parents for a 30 minute group session for a discussion of those particular problems shared in common and techniques parents have used for solving them. These parents also might observe the class for 30 minutes as a group. During that observation period the lead teacher might meet with the parents while the monitor takes her place in class. This gives parents opportunity to ask questions of the lead teacher and also to observe the monitor with their children.

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*The Parent Planning Conference is described in Chapter Three.

Whatever type of session is used by parents and monitor, it is essential that an exchange of information occur and that parents and monitors establish specific objectives.

In the course of an appointment, several questions should be kept in mind, to provide a direction for the exchange of information:

a) What are the objectives? (Reasons for the conference, observation, home visits, etc.) If the objectives can be stated clearly, parents can be helped to see a purpose more clearly.

b) What are the child's current RORF major treatment objectives?

c) How are objectives being met in the center classroom?

d) How have the techniques changed since last time?

e) How has the child's behavior changed since last time?

f) Have these changes been noted at home?

g) What level of parent participation was recommended at staffing and what directions should center services take with the parents?

h) Which objectives are parents working on at home?

i) What activities are the parents using to meet these objectives?

j) Why are teachers using certain techniques (. . . to accomplish specific objectives)?

k) How comfortable do the parents seem?

l) What elements in the program do they respond to?

m) What tends to cause parents to withdraw from open exchange?

n) What were the high priority problems originally identified by the parents on the RFCL?

o) To what extent are these increasing or decreasing with each visit?

p) What techniques do the parents see as reasonable for them to use at home to solve specific problems?

A session with parents and the treatment team monitor is viewed as an exchange of information between persons concerned with the child's well being. It is as important to obtain parents' perceptions of problems, goals, growth and change in their child, as it is to present to them Rutland Center's report of progress, problems, and change. Some parents may freely offer information about their child, but in some cases, the monitor may have to ask questions or otherwise draw the parent into the conversation. In order to facilitate this type of dialogue, the general tone of the conference should be congenial, friendly, and concerned. In other words, parents at Rutland Center should be made to feel comfortable enough to talk about their child.

One of the first things conveyed in a parent-monitor session is a general orientation to the child's center classroom and daily treatment program. This is especially important for parents of children who are new or for parents of children who are moving from one stage of therapy to another. This orientation might include a short explanation of the general goals for that stage of therapy in the four curriculum areas, a discussion of daily class activities using the class schedule, and a brief discussion of how this differs from the child's previous class. It is important to make this orientation as specific as possible, in order that the parents understand what their child does when he attends class at the center.

Generally, conferences will be focused on information exchange. In reporting progress to parents, it is important to keep in mind two factors; a) that obvious success is important in conveying a sense of confidence that the child is progressing; and b) that specific examples will help to clarify success. To make communication as clear as possible actual classroom instances and materials may be described.

Various evaluation data such as the RFCL, SWAN, and RORF are used to report progress to parents.* Pertinent data can be summarized from these records prior to the conference by the monitor for use during the conference.

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*The instruments are contained in the Appendix and are discussed in Chapters Three (RFCL) and Four (SWAN and RORF).

The RORF can be used to show movement from one goal to the next in each curriculum area. Although it is suggested that the RORF be used as a framework for reporting progress, the report should be limited to discussing only goals which were or will be major focuses for the child. When using the RORF, the following steps might be taken to define progress:

a) define a specific RORF objective to be mastered

b) describe behavior which constitutes mastery

c) describe child's past behavior

d) define child's progress in relation to mastery of the specific objectives

At this point (discussion of child's progress toward mastery) it is imperative to obtain the parents' perception of where the child is in relation to the objective. It is important also to help parents to relate these current objectives to objectives at home and to original referral problems (RFCL). By obtaining the perceptions of parents concerning "what has made the difference" in eliminating a problem, and by supporting them in their attempts toward reaching their objectives, more effective home management will be a natural outcome.

Any session also should identify factors which are impeding or fostering change at the school, home, or center. It is the responsibility of the treatment team to recognize parents' techniques which have fostered change and to encourage parents to develop adaptations when necessary for use at home.

Although change usually produces positive behaviors it is important to help parents understand that acting-out behavior can also be a natural outcome of positive growth, and that such behavior can be re-channeled and result in further growth for the child. By reporting on such possible behavioral changes, the feeling that all persons involved with the child are working together is reinforced, and no one is surprised by a sudden, drastic change in a child's behavior.

After the child has been in treatment for some time, future plans for each child should be discussed with both the parent and school. These plans may consider either continuation or termination of services. In either case the decision should be presented in terms of progress in mastering Developmental Therapy objectives and in reduction of problems originally identified on the RFCL. If the decision is made that a child should continue at Rutland Center, some indication should be given to the parents as to what goals should be accomplished before their child can be terminated. Any change in classrooms at Rutland Center for the next quarter should also be discussed in general terms. This is especially applicable if a child is to change from one stage of therapy to another.

Each session should end with a summary of what has been discussed, observed, and planned for that week at home. Parents are given a specific time for the next appointment also. Finally it is important to walk to the front door of the center with parents. It is essential also that parents feel that they will be recognized and welcomed the next time they come to the center and that their participation and involvement is significant.

Immediately after each session a Parent Participation Card is completed by the monitor and returned to the Evaluation Team.* After data are recorded, this card is filed with previous cards thereby recording, sequentially, the type of parent involvement and the outcomes.

The 10th Week Conference

The 10th week conference provides an opportunity for parents, the monitor, and the lead teacher to exchange and review information concerning the child's progress during a ten week treatment period at the center and at home.

The main purposes of the conference are a) to mutually exchange information about the child's progress at the center and at home during the ten week period; and b) to mutually plan for modifications in objectives, program, and procedures for the next ten week treatment period.

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*See page A-99 for a description of the Parent Participation Card in the Appendix, Forms 32 and 33 .

For parents participating in a minimal way, the 10th week conference is the only opportunity for them to become acquainted with techniques and materials used at the center and to inform the treatment team about management of the child at home, his behavior, and other changing circumstances which may affect his behavior. In either situation, the 10th week conference is a vital factor in the treatment team's work with the parents and the child.

The lead teacher conducts the 10th week conference and the monitor participates. However, the monitor can assume conference leadership if it appears to be of support to the parents.

Prior to the conference, the lead teacher and the monitor should consider the following: a) who will attend the conference; b) who will open and close the conference; c) what would make the parents comfortable; d) review the current center, home, and regular school situations; e) review results of past contacts; f) summarize the broad, general messages needed to relate to parents; g) consider implications for home management; h) consider relevance of discussing future plans for child (continue at the center, consider termination or services elsewhere); i) prepare site of conference and room arrangement to make parents comfortable.

There are nine points to cover in the 10th week conference. The points are listed in Figure 11.

The 10th week conference is recorded on the Parent Participation Card. A summary of the conference is written on the back of the card, by the monitor, and it is turned in to the evaluation team for data collection and subsequent filing. Agreed upon changes in amount and type of parent participation for the next ten week treatment period are recorded on the back side of the card also.

Evaluation

Five administrative objectives and four outcome objectives have been established to evaluate the Parents' Services. These objectives have corresponding procedures (i.e., actual activities performed by the staff to achieve these objectives) and evaluations (i.e., specific forms of data which can be drawn from the activities by the evaluation team).

Administrative Objectives

Evaluation of the administrative objectives listed in Figure 12 is completed from data obtained from the Parent Participation Card. Summary data from these cards should reveal that a) parent referrals were received and accepted; b) information concerning their child's Rutland Center program was given to parents; c) information concerning test

Figure 11

INFORMATION TO BE COVERED IN 10TH WEEK CONFERENCE OF PARENTS AND TREATMENT TEAM

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1) Specific progress in the four curriculum areas is discussed using concrete examples. The RFCL and the RORF may be used when appropriate. The progress is discussed in terms of the referral problems and the therapeutic goals. The parents are asked what changes they have noted at home.

2) Factors that are impeding or fostering change are discussed, including the techniques used at the center, at home, and at school.

3) Behavior that can be expected at home and in the classroom is discussed, so that the parents will be prepared for new behaviors in their child and new alternative responses for themselves.

4) Implications for home management, such as the use of the Developmental Therapy Objectives for Home Use, are discussed.

5) Plans for the future are discussed. If the child is close to being terminated, this is discussed at this time; or if the child is being moved to another level of therapy, the implications are discussed.

6) A classroom and program orientation is given, especially for the new parents. This includes explaining the class schedule, telling about activities, etc. For the parents whose child has been in the program, program changes are explained. Parents are shown the child's work folder, and particular changes over the ten weeks are discussed.

Figure 11 continued

Figure 11 continued

7) Parents are asked for their perception of problems, growth, or changes.

8) The parents are asked to summarize their response to the overall progress of the child during the ten week period. The RORF Summary and parents' views may be used to help parents develop home objectives and activities to meet these objectives.

9) Parents are encouraged to extend their commitment to participate further in center parent programs.

10) Parents are given information about the new schedule, new class assignments, transportation, and new objectives to be used. Whenever possible parents should be introduced to the monitor of their child's new treatment team and should be advised that the new monitor will call them during the second week of the program for an appointment.

Figure 12

ADMINISTRATIVE OBJECTIVES, PROCEDURES, AND DATA USED TO EVALUATE THE PARENT SERVICES

Objective I

To accept referrals from parents when center services are appropriate.

Procedure: Phone calls; conferences

Evaluation: Number of parents' referrals received/accepted

Objective II

To disseminate description of Rutland Center service to parents.

Procedure: Parent Intake Conferences

Evaluation: Number of parent conferences; number sets of materials disseminated to parents

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Objective III

To provide parents with information concerning results of testing the referred child.

Procedure: Parent Planning Conferences with monitor and intake social worker

Evaluation: Number of Parent Planning Conferences held

Objective IV

To plan appropriate parent services and to schedule each parent for type of parent service selected.

Procedure: Parent Planning Conferences with monitor and intake social worker

Evaluation: Number of parents recommended and scheduled for the three levels of participation; number of parents keeping first scheduled appointment with monitor

Figure 12
(continued)

Objective V

To conduct selected services for parents in ten-week treatment intervals.

Procedure: Five types of service: Conferences, Observation, Training in Classroom, Home Program, Parent Association

Evaluation: Number of parents and frequency and type of contacts during ten week period; number of cancelled or unkept appointments results were given to parents of every child tested; d) planning for appropriate help for parents was conducted for each parent, e) parents were served in a variety of ways.

Outcome Objectives

The outcome objectives, procedures, evaluations, and data sources are summarized in Figure 13. Evaluation of the four outcome objectives for parent services is completed from data obtained from four sources: the Parent Participation Card, and the Parent Activity Card, described below; the treatment sheet, described in Chapter Three; and the School or Agency Contact Card described in Chapter Six.

The Parent Participation Card

The Parent Participation Card is used by the evaluation team to quantify the number and type of parent contacts actually conducted. This record also documents the major purposes of each contact. For parents participating at the "Extensive" level, there should be nine to ten such cards during the ten week quarter.

These data are summarized weekly and monthly and are then filed in the Parent Participation Card File. This system provides the next quarter's treatment team with a record of a) how much the parent participated; b) the type of service

Figure 13

OUTCOME OBJECTIVES, PROCEDURES AND EVALUATION FOR PARENT SERVICES

Objective I

To encourage parents and staff to share information concerning the child's needs and developmental progress in behavior, communication, socialization, and academics during the period of the child's treatment at home and Center.

Procedure: Parent and monitor working in selected parent program

Evaluation: Type and amount of information exchange occuring

Data Source: Parent Participation card, "content" section

Objective II

To encourage parents involvement with the center to the extent recommended at staffing and at ten week intervals during the period of the child's treatment.

Procedure: Assessment of parents and family strengths and limitations at staffing with recommendations for "minimal", "intermittent", or "extensive" involvement; periodic review and recodifying involvement, with parents, at 10th week conference

Evaluation: The extent to which parents participate in center programs as compared with recommendation made at staffing and at each ten week interval

Data Source: Treatment sheet prepared at staffing; Parent Participation Card ("Type of Participation" section and "Summary" section)

Figure 13 continued

Objective III

To stimulate parents interest in the child's growth and development so that during the second, and subsequent, ten week treatment periods they will develop various appropriate activities and procedures to use with their children at home.

Procedure: By the first 10th week conference (or earlier if parent is ready) monitor and parent discuss the child at home and ways parents can assist the center at home; small, specific objectives are established

Evaluation: Parents develop home activity to meet objective and rate activity as to its effectiveness; monitor rates activity as to appropriateness for childs growth and development

Data Source: Parent Participation Card ("Content" section, H1 - H4); Activity Card

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Objective IV

To provide crisis help and assistance to parents at their request, obtaining supportive help for family and personal needs from other community resources.

Procedure: "Walk in" or "On call" availability of monitor to parents, day or evening

Evaluation: Number of parent requests for non-scheduled contacts with staff and number of contacts with community agencies concerning the family

Data Source: Parent Participation Card; School and Agency Contact Card they received; and c) the primary objectives of the sessions. The Appendix contains a copy of the Parent Participation Card (Form 32) and directions, Coding for Parent Participation Card (Form 33).

Activity Card

After a particular objective is identified by the parents and monitor; the objective is recorded on an Activity Card.* The monitor discusses the objective with the parents and may give some examples of how to implement the objective at home. However, most of the ideas for implementation, it is hoped, will come from the parents.

On the back of the Activity Card, which the parents often take home, is space for parents to write down the activities they have used in implementing the objective on the front of the card. The monitor may record the activity for a parent not choosing to write it down on the Activity Card himself. Responsibility for implementing the activity is placed upon the parents. By using the Activity Card, the parents and the treatment team will have record of actual activities used to accomplish objectives; and the evaluation and treatment teams will also have a cumulative record of activities used by all parents to reach particular objectives.

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* Translations of Developmental Therapy Objectives for parents are being field tested during 1972-1973 but are not included in this volume.

The Activity Card is contained as Form 34 in the Appendix.

When parents have developed various activities and procedures for a particular objective, they are asked by the monitor to rate whether or not the activity was effective in meeting the objective. This rating is recorded on the back side of the Activity Card. Immediately following the session, the monitor records his rating as to the appropriateness of the activity for the child's growth and development at the bottom of the card.

Chapter Eight

THE GEORGIA PSYCHOEDUCATIONAL CENTER NETWORK

Herbert D. Nash
and
Mary Margaret Wood

Introduction

It is evident that concern is increasing over the problem of protecting the civil liberties of disadvantaged school age children who are being excluded from school due to disturbed, delinquent behavior. Judicial systems at local, state and federal levels are influencing and will continue to influence the actions of public school personnel in the adequate planning and programming for these children. However, this concern and legal pacesetting does not really answer cooperative, methodological and communication problems between agencies which result in a poorly developed delivery of programs and services. Further problems arise because so often programs are developed with little coordination and involvement of consumers.

Approximately one-half percent of Georgia's child population ages 0-14, are severely emotionally disturbed to the extent that they cannot make satisfactory adjustments within their environment without special programs of intervention. Further, a majority of these children are from disadvantaged cultural and economic backgrounds. In the past, there has not been effective coordination between disciplines and agencies in providing services to the severely emotionally disturbed, which has resulted in a poor delivery system. Where such programs have been developed, they generally have taken a direction toward institutionalization, particularly with the disadvantaged who do not enjoy other private resources, an inherent injustice to individual children who might be served in their own communities if services were available.

Where programs for the emotionally distrubed have developed in public schools, they generally have served mildly to moderately **disturbed** children rather than those who are severely **disturbed.** Also, few programs have been developed that included consumer and parent participation.

The psychoeducational center network in the State of Georgia is designed as a comprehensive community based system to serve emotionally and behaviorally disturbed children aged 0-14 and their families. It is a coordinated program between mental health, special education, the University of Georgia, local school systems and mental health centers, funded by the State of Georgia and matching federal funds from Title IV-A of the Social Security Act, through the Georgia Department of Human Resources, Division of Family and Children's Service.

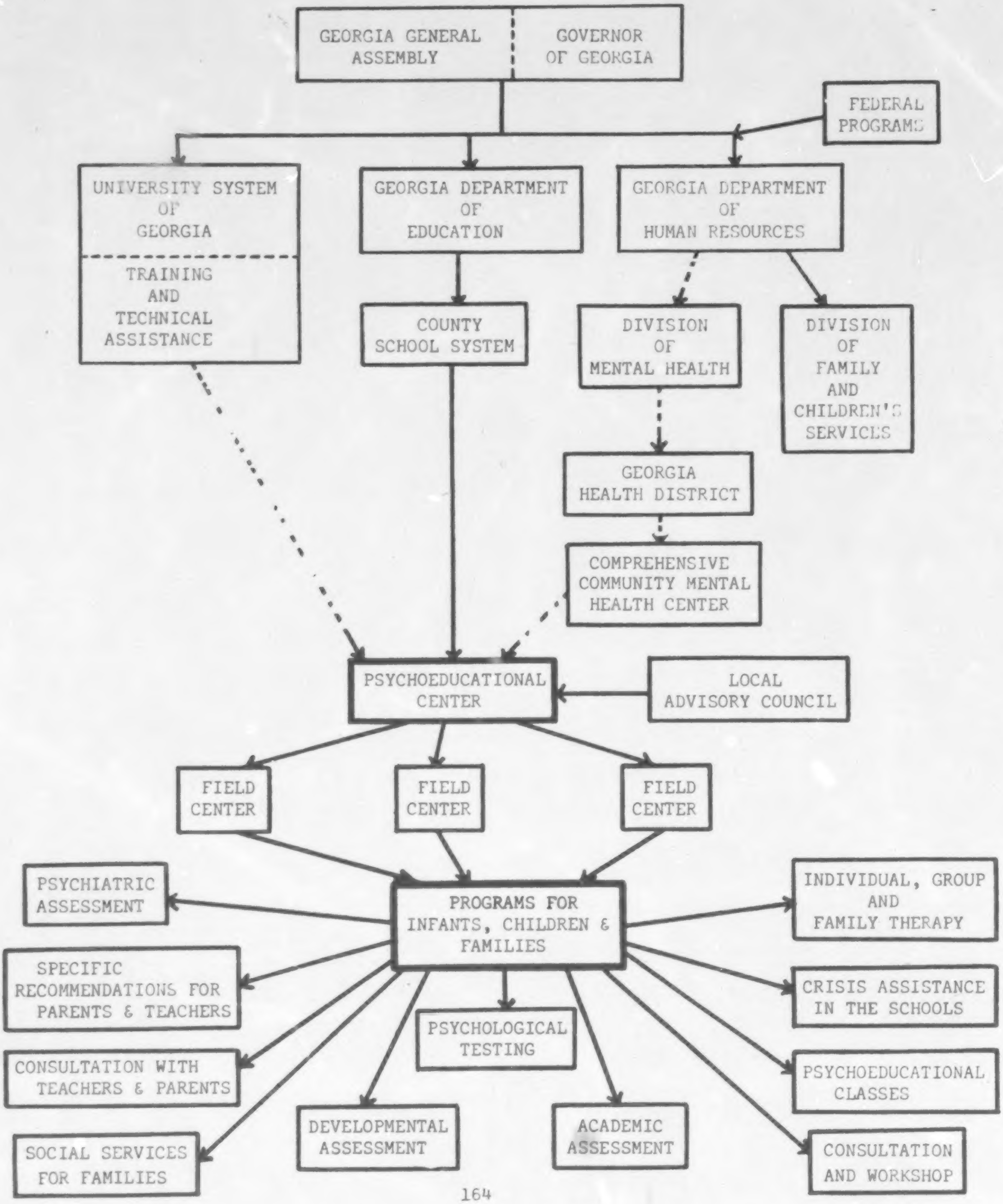
Because services for emotionally disturbed children are the joint responsibility of education and mental health programs, the Department of Education and the Department of Human Resources decided to plan and implement a joint service delivery system for severely disturbed children and their families. This system, the Georgia Psychoeducational Center Network, is part of a comprehensive mental health service program for children. The program is developed through both local school systems and decentralized health districts.

Figure 14 presents the agency linkage for administration of the Georgia Psychoeducational Center Network. Coordination of the network is the responsibility of the Georgia Department of Education, office of the state director of Special Education. The Georgia Department of Human Resources, Division of Mental Health, provides clinicial staff through district mental health centers. Each local center is largely autonomous and governed by a local board comprised of district mental health, public education officials, parents, and other community people. Each center will serve one mental health district. Georgia has thirty-four such districts primarily based upon population.

The network started operation July 1, 1972 with centers in Athens, Savannah, Brunswick, Valdosta, Thomasville, Carrollton,

Figure 14

AGENCY LINKAGE FOR ADMINISTRATION
OF THE
GEORGIA PSYCHOEDUCATIONAL CENTER NETWORK


GEORGIA GENERAL ASSEMBLY
GOVERNOR OF GEORGIA
FEDERAL PROGRAMS
UNIVERSITY SYSTEM OF GEORGIA
TRAINING AND TECHNICAL ASSISTANCE
GEORGIA DEPARTMENT OF EDUCATION
GEORGIA DEPARTMENT OF HUMAN RESOURCES
COUNTY SCHOOL SYSTEM
DIVISION OF MENTAL HEALTH
DIVISION OF FAMILY AND CHILDREN'S SERVICES
GEORGIA HEALTH DISTRICT
COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTER
PSYCHOEDUCATIONAL CENTER
LOCAL ADVISORY COUNCIL
FIELD CENTER
FIELD CENTER
FIELD CENTER
PSYCHIATRIC ASSESSMENT
PROGRAMS FOR INFANTS, CHILDREN & FAMILIES
INDIVIDUAL, GROUP AND FAMILY THERAPY
SPECIFIC RECOMMENDATIONS FOR PARENTS & TEACHERS
CRISIS ASSISTANCE IN THE SCHOOLS
PSYCHOLOGICAL TESTING
CONSULTATION WITH TEACHERS & PARENTS
PSYCHOEDUCATIONAL CLASSES
DEVELOPMENTAL ASSESSMENT
ACADEMIC ASSESSMENT
SOCIAL SERVICES FOR FAMILIES
CONSULTATION AND WORKSHOP

and Waycross. Six other centers received funds to begin active planning September 1, 1972.

By January 1, 1973 the network will serve approximately 600 children in the first seven centers and 900 in the outreach programs, for an estimated total of 1,500 children. Newly phased in centers will begin to serve children on January 1, initiating service for 600 children on January 1 in Milledgeville, Dalton and Gainesville and 412 children on March 1 in Americus, Dublin and Waynesboro. Of these 1,000+ children, approximately 400 will be served in the centers and 600 in the outreach programs.* By the end of 1973 approximately 2,585 severely emotionally disturbed children should be receiving services.

The University of Georgia, through the Technical Assistance Office, will provide continuing evaluation of the centers as they become operative, insuring that effective methods of helping severely emotionally disturbed children are shared and that ineffective approaches are discarded. The Technical Assistance Office will also help design and write program proposals, provide consultation on treatment, and assistance in staff training.

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*These are conservative estimates of numbers served. Actually operation of several centers indicates that most centers will be able to extend service significantly beyond the specific target number.

Goals and Objectives

Network Goals and Objectives

The network's major goal is to provide services to severely emotionally and behaviorally disturbed children which will enable them to participate in regular educational programs and pursue a normal course of education or social adjustment, eventually holding jobs and participating as productive members of society and thereby reducing or eliminating the need for extended state support.

Specific network objectives designed to meet this overall goal are:

(1) to serve seriously disturbed and deprived infants, children and their families by expanding or establishing 34 psychoeducational centers in each mental health district of Georgia with outposts to serve rural children geographically isolated from the proposed centers.

(2) to establish a Technical Assistance Office to assist the proposed centers with professional consultation and training in the following areas: (a) overall program design--administrative, service, evaluative aspect; (b) recruitment, pre-service, in-service and continuing education for staff; (c) evaluation design and implementation including assistance in developing center's program objectives, methods for documentation of program processes and effectiveness.

Goals for Each Center

The following general goals are established at each center:

(1) to provide combined special education and mental health services to severely disturbed children and their parents (up to one-half percent of a district's child population between the ages of birth and 14 years);

(2) to help break the cycle of poverty or economic hardship imposed on a family by a child with special emotional or behavioral problems by rehabilitating and reinforcing the child and his or her family, hopefully allowing the child and family to lead a normal life.

(3) to develop community and public school involvement through a system for information and training regarding the center's purposes and procedures;

(4) to develop and implement a staff training program which will include but not be limited to all staff; e.g. professionals, paraprofessionals, parents, students, and volunteers.

(5) to develop and implement an evaluation system which will document the program process, describe the children served, and document program effectiveness.

Services to Children and Families

Referral Services--Testing, diagnosis, evaluation, individual program planning and parent consultation are available for severely behaviorally and emotionally handicapped preschool children (ages 5-11) and school age children (ages 6-14).

Referrals may be accepted from parents, schools, early childhood developmental programs, ministers, juvenile courts, or other child-serving agencies. However, no child is seen for any center service without parent approval (signed) and participation in at least one "intake" conference prior to or concomitant with testing of child and one "post-testing" conference summarizing results of testing and recommendations. Referrals will be made for both parents and children to the other agencies when appropriate.

Special Classes--Psychoeducational services such as a special therapeutic class or group, or a modified school program, are offered for children who need special treatment services not ordinarily available in a school setting or with available school resources.

Classes should be available four to five days a week for preschool children and two to five days per week for school age children. The amount of time each child spends at the center each day is a decision of the center staff, considering the nature and severity of the child's problem, the prescribed program and objectives, the home and neighborhood situation and school conditions. However, the center staff works to maintain on-going enrollment and participation in a normal school program while the child is enrolled in a center psychoeducational program.

In addition, periodic review of each child's progress at the center is summarized by the staff and discussed with the child's parents and regular school teacher. Ten weeks is recommended as the longest interval for review of progress.

Parent Services--Services are available for the family of each child served at the center. Preferably these services are planned jointly between staff and parent. Agreed upon goals are established with each parent prior to initiation of the parent and child services.

It is desirable for center personnel to see themselves as child and family advocates, assisting them in whatever way indicated to enter the helping agency network in the community.

As indicated in Figure 15,services to families may be offered in a number of ways. First, the social worker will establish rapport with the family and attempt to assist the family to understand the program of the center. At this point the social worker may find that the family has one or more basic unmet needs which may be met by proper referral or direct services. The family will be assisted in overcoming any difficulties which may prevent the child from becoming involved in the program of the center. The special inhibiting factor associated with poverty must be dealt with in order to insure that the family feels welcome to the services.

A second type of service provided by the social worker would be information conferences. These conferences might be held in groups or individually and would be for the purpose of providing child development information, interpreting test results and communicating treatment programs and general child management techniques.

Many of these parents may need help in order to maintain their parental role, including management of the child and their relationship with the child. The social worker may support the parental role by supporting the things which the parent does well with the child. The social worker may meet some of the dependency needs of the parent and thereby help him to handle the dependency of the child.

The social worker may be called upon to intervene in crisis situations which occur from time to time within the family, such as sickness of a family member, loss of income, death of a grandparent, new relationships, threatened marital breakup. The social worker may enable the family to grow emotionally through crises.

The social worker also may engage in ongoing parent counseling of an interpersonal or intrapsychic type. Often a child may be unable to make any progress until a marriage is made more stable, or parents may need individual help with a variety of personality problems which are interfering with the child's emotional development.

Family followthrough is another activity of the social worker. After the child has discontinued his work in the psychoeducational center, the social worker may need to continue working with the family in order to insure that the child can remain in public school full time. The social work staff will continue to be available to the family for help in crises and routinely follow up cases at three months, six months and one year after the child is terminated at the center.

Figure 15

Services to Families

Type of Service	Location of Service	Individual/Group
1. Initial Referral and Intake Service	Center	Individual
a. advocacy-intervener	Home	
b. needs providing	School	
c. reporting information		
d. establish nature of future contacts		
2. Information, Feedback Conferences	Center	Individual/ Group
a. child development information		
b. test interpretation	School	
c. communication of service program and child's progress at center	Home	
3. Parental Role Support	Center	Individual/ Group
a. management of child	Home	
b. relationship with child		
4. Crisis Intervention	Center	Individual
a. process	Home	
b. reactive	School	

Figure 15 Continued

Figure 15 Continued

5. Parent Counseling	Center	Individual/ Group
a. Interpersonal	Home	
(1) marriage counseling		
(2) family counseling		
b. Intrapsychic		
6. Family Followthrough	Center Home	Individual/ Family
7. Neighborhood Followthrough	School Neighborhood Community Agencies	

School Liaison and Other Community Services

Each center must develop a system for maintaining a smoothly working process with each participating school system and preschool programs for:

(1) identification and referral;

(2) communication of testing results and recommendations;

(3) coordination of effort between regular school (preschool) personnel and center staff working with a child;

(4) periodic reporting of progress, both ways.

In addition, center personnel have a responsibility to cooperate and provide leadership with all community agencies, including preschool and day care programs, serving children. Such activity should promote desirable mental health practices for parents and children and provide assistance to parents in effective utilization of existing community resources.

Center programs are offered to public school personnel on a planned basis for the purposes of:

(1) providing information about center programs;

(2) providing observation of ongoing programs of service for school superintendents, principals and teachers who have referred children;

(3) providing in-service training at the center for teachers, principals and other community mental health professionals.

In addition to such activities at the center, staff become involved in community activities through local citizen groups, information to public news media and participation in community organizations supporting services to children. It is through active involvement in many aspects of community life that center staff are able to utilize community resources for referred children and their families. Further, community support of a center and acceptance of children with emotional problems are essential elements in the eventual success or failure of the center's program.

Interdisciplinary and Interagency Cooperation

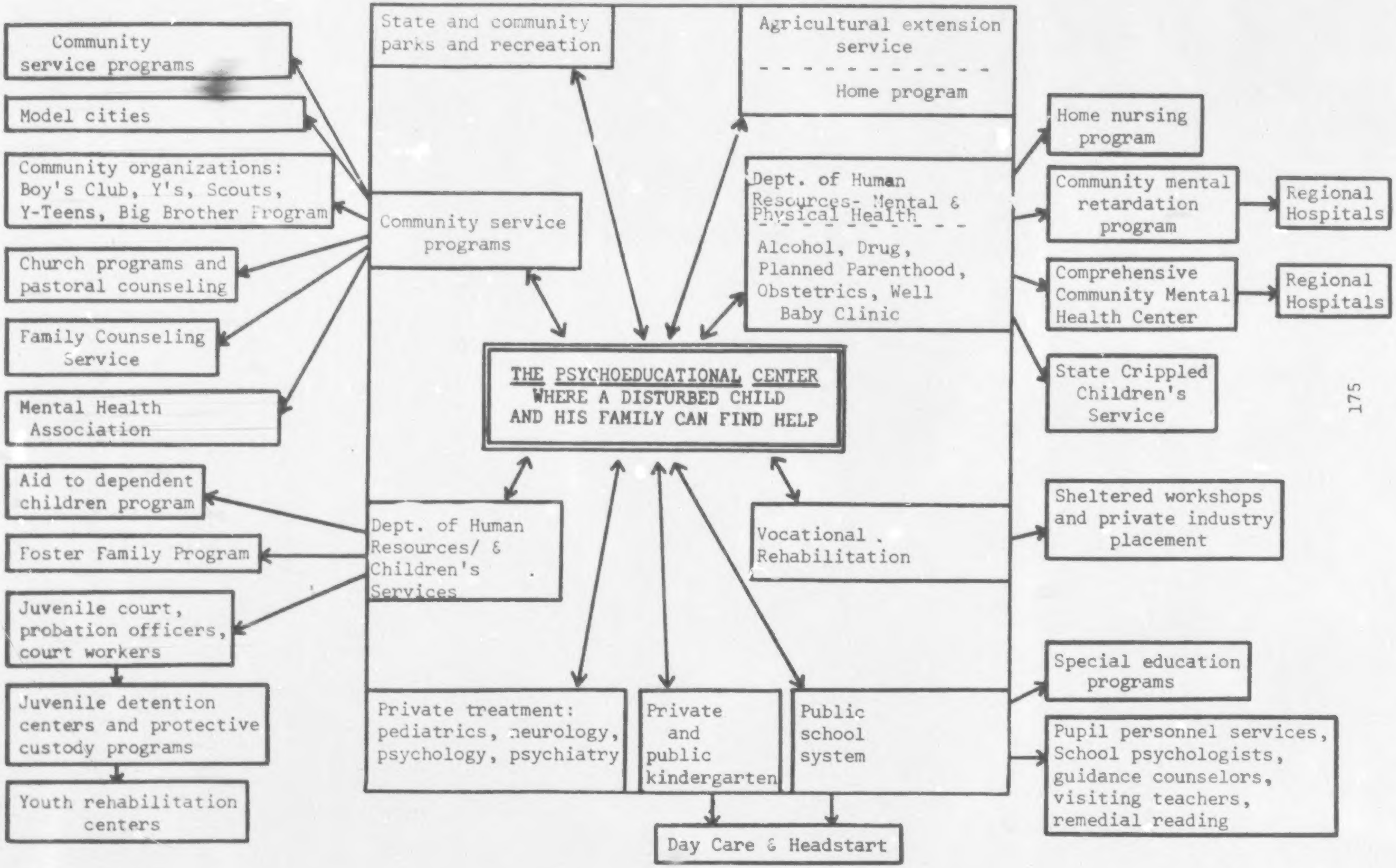
As the network will deliver services that unify educational, developmental and psychological services, interdisciplinary and interagency cooperation at the state and local level are essential.

Figure 16 portrays the psychoeducational center as a source for coordinated services for disturbed children. Such cooperation makes the network unique and insures that it is effective and able to deal with a child and his total environment. No center in the network can operate effectively in isolation from any of the professional resources of its local area.

The staff of each center includes professionals from several disciplines--psychiatrists, psychologists, social workers and special educators. In addition to delivering its particular service program, this staff serves as supplementary to and supportive of local educational, day care, childhood development and mental health programs. The director of each center is responsible for coordinating the services of the psychoeducational center with these other programs and services. This coordination is faciliated by the employment of center personnel both by local school systems and health departments.

The state level administrative and Technical Assistance offices also enjoy the talents of professionals from the disciplines of special education, social work and psychology. A Special Task Force is responsible for advising the State Department of Education administrative staff of available professional resources in both public and private institutions which might assist in the network program.

FIGURE 16
COORDINATED
SERVICES FOR DISTURBED CHILDREN


THE PSYCHOEDUCATIONAL CENTER
WHERE A DISTURBED CHILD
AND HIS FAMILY CAN FIND HELP
State and community parks and recreation
Agricultural extension service
Home program
Community service programs
Dept. of Human Resources- Mental & Physical Health
Alcohol, Drug, Planned Parenthood, Obstetrics, Well Baby Clinic
Dept. of Human Resources/ & Children's Services
Vocational Rehabilitation
Private treatment: pediatrics, neurology, psychology, psychiatry
Private and public kindergarten
Public school system
Day Care & Headstart
Community service programs
Model cities
Community organizations: Boy's Club, Y's, Scouts, Y-Teens, Big Brother Program
Church programs and pastoral counseling
Family Counseling Service
Mental Health Association
Aid to dependent children program
Foster Family Program
Juvenile court, probation officers, court workers
Juvenile detention centers and protective custody programs
Youth rehabilitation centers
Home nursing program
Community mental retardation program
Regional Hospitals
Comprehensive Community Mental Health Center
Regional Hospitals
State Crippled Children's Service
Sheltered workshops and private industry placement
Special education programs
Pupil personnel services, School psychologists, guidance counselors, visiting teachers, remedial reading

On the local level, each psychoeducational center cooperates and plans with comprehensive community mental health centers to provide comprehensive, coordinated services for severely emotionally disturbed children and such other services as shall be mutually developed. The psychoeducational center coordinates with all local agencies involved in the delivery of services to emotionally disturbed children, receiving referrals from the school system, the health department, existing community early childhood development programs, existing day care programs and community mental health centers.

Training

Each center director develops a program of in-service training for center staff--professional, paraprofessional and volunteer--which relates to more effective accomplishment of center objectives. The Technical Assistance Office is available to assist center directors in planning and carrying out these programs.

Staff preparation at each psychoeducational center are developed around three types of training activities: *recruitment and pre-service*; *in-service* for on-the-job enhancement of skills and *professional* for increasing staff credentials, formal education and mobility up the career ladder. All staff participate in in-service training. All staff also are encouraged to participate in professional training and given assistance in this endeavor by the director and a professional staff member designated to serve as Coordinator of Training. The center director has primary responsibility for all staff training programs and their evaluation.

The Technical Assistance Office provides assistance to each center, upon request, in developing and conducting procedures appropriate to meet the stated training objectives. Assistance in evaluation of training is provided by this office also.

Direct consultation and use of training media from the Technical Assistance Office is available upon request. Rutland Center training programs, special institutes, demonstration, and workshops can be arranged at a center upon request to the Technical Assistance Office.

Evaluation

Each center director develops a system for evaluating all project objectives and procedures. The Technical Assistance Office is available to assist center directors in developing and implementing the evaluation system and relating the information gained from such a system to the various project objectives and procedures.

Program evaluation at each psychoeducational center is based on the individual center objectives, which include providing needed services to children and their parents, obtaining community and public school involvement, developing and implementing a staff training program and documenting the treatment process. A staff member, designated as center evaluator, assists the center director in developing and implementing the evaluation system.

Standard service data are collected from each center, in addition to the individual treatment data for each child. The data are reported monthly by each center, collated and summarized by the Technical Assistance Office and reported back to each center and to the state administrative office. In this way, the network activities and each center activities can be followed. Forms 35,36 and 37 in the Appendix are copies of the *Network Monthly Summary for Children Services*, *Explanation of Monthly Summary Reports*, and *Network Monthly Summary for Parents' Services*. Form 38 includes the format for collecting *Network Demographic Data*.

The State Board of Education approves centers annually, reviewing these data and considering recommendations from the Special Task Force and the Technical Assistance Office.

Benefits

The network is in itself a specialized service for exceptional children. It will constitute one alternative to the institutionalization of children with serious emotional disturbance who have difficulties remaining in a normal school environment or who manifest severe emotional problems at the preschool age. The network is a vital part of a total program of prevention of mental illness and severe social maladjustment. Hopefully, the network will intervene in a child's and family's problems sufficiently early in the child's life to reduce or eliminate the behavioral and emotional difficulties that might later develop into profoundly debilitating behavior.

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FORM 1

STAFF FEEDBACK QUESTIONNAIRE

Description:

A two-part, three-page form designed to elicit Rutland Center staff impressions and views concerning the entire center program. The first part is composed of 15 questions covering areas of general importance. The second part is composed of 23 topics, each rated on a five-point rating scale from "System Working Well" to "System Not Working Well" and space is provided for no answer in the event the staff member completing the form feels he does not have enough information to rate the problem.

Directions:

Please give us your reactions to the following questions and add other comments you may wish to make. This feedback will be used to help plan for increased project effectiveness and for improvements in staff working conditions.

Use:

The form is employed at the end of Fall Quarter and the end of Spring Quarter. The information obtained is summarized using the same format, and the summary information is then returned to each staff member. Also, this form provides internal evaluation of the project.

FORM 1
(Continued)

STAFF FEEDBACK QUESTIONNAIRE

Please give us your reactions to the following questions and add other comments you may wish to make. This feedback will be used to help plan for increased center effectiveness and for improvements in staff working conditions. Please be specific, frank, and honest in responding. This information will be summarized at our first staff meeting in June.

1. Do you feel, in general, that you have been able to accomplish what you want professionally under the present work assignments?

   Yes____ No____ Comment/Suggestion____________________

2. Do you feel, in general, that your work load has been too heavy?

   Yes____ No____ Comment/Suggestion____________________

3. Do you feel that the physical arrangements, equipment and supplies have been adequate for you to accomplish what you wanted professionally?

   Yes____ No____ Comment/Suggestion____________________

4. Do you feel that there have been too many activities to participate in outside of your particular area of effort (e.g., evaluation, staff meetings, workshops, etc.)?

   Yes____ No____ Comment/Suggestion____________________

5. Do you feel that you have received adequate information and have an understanding of the center's goals?

   Yes____ No____ Comment/Suggestion____________________

6. Do you feel that your job needs further clarification?

   Yes____ No____ Comment/Suggestion____________________

7. Do you feel that the center has generally moved in the direction you had anticipated when you accepted a position with the center?

   Yes____ No____ Comment/Suggestion____________________

FORM 1
(Continued)

8. Do you feel that you have been kept sufficiently informed of center progress?

Yes_____ No_____ Comment/Suggestion______________________________
____

9. Do you feel that you have made a contribution to the center program?

Yes____ No_____ Comment/Suggestion______________________________
____

10. Do you feel that there has been adequate opportunity for you to make suggestions and contribute to the center output in your particular area of effort?

Yes_____ No_____ Comment/Suggestion______________________________
____

11. Do you feel that there has been adequate opportunity for you to make suggestions and contribute to the center output in other areas of the projects?

Yes_____ No_____ Comment/Suggestion______________________________
____

12. Do you feel that there is the correct balance in the number of staff members employed for each area of effort, e.g., secretaries, social workers, evaluators, psychologists, psychiatrists, directors, treatment teams?

Yes_____ No_____ Comment/Suggestion:_____________________________
____

13. Do you feel that the center is using an equitable pay scale for all personnel within the center?

Yes_____ No______ Comment/Suggestion_____________________________
____

14. Do you feel that the center pay scales are competitive with salaries nationally?

Yes_____ No______ Comment/Suggestion_____________________________
____

15. Do you feel that the monitoring system has been helpful in providing feedback for program modification?

Yes____ No_____ Comment/Suggestion_______________________________
____

FORM 1
(Continued)

16. Rate the following topics:

	System Working Well	--------	--------	System Not Working Well		No Answer
Staff cohesiveness	1	2	3	4	5	N
Staff communication	1	2	3	4	5	N
Treatment team communication	1	2	3	4	5	N
Service to children	1	2	3	4	5	N
Service to parents	1	2	3	4	5	N
Community relations	1	2	3	4	5	N
Neighborhood followthrough	1	2	3	4	5	N
School liaison	1	2	3	4	5	N
County school work	1	2	3	4	5	N
Dissemination of model	1	2	3	4	5	N
Staff training	1	2	3	4	5	N
Volunteer program	1	2	3	4	5	N
Aide/paraprofessional training	1	2	3	4	5	N
Evaluation component	1	2	3	4	5	N
Outside professional contacts and communication	1	2	3	4	5	N
Secretarial support	1	2	3	4	5	N
Custodial support	1	2	3	4	5	N
Transpo tion	1	2	3	4	5	N
Record eeping	1	2	3	4	5	N
Intake process	1	2	3	4	5	N
University relationships	1	2	3	4	5	N
Public School relationships	1	2	3	4	5	N
Surrounding county relationships	1	2	3	4	5	N

17. Any comments or additional suggestions on back

FORM 2

TRAINING SESSION EVALUATION FORM

Description:

A one page form composed of seven questions relating to a training session presentation.

Directions:

Complete the form.

Use:

Answers are summarized both numerically and by comments. Copies of the summary are given to the presentor and all members of the administrative staff to evaluate the topic presented.

FORM 2
(Continued)

TRAINING SESSION EVALUATION FORM

Topic of Session: ____

Person Presenting: ____

1. Was this session well organized? ____Yes ____No

2. Was this session stimulating and interesting? ____Yes ____No

3. Was/were the information and/or procedures presented during this session presented clearly? ___Yes ___No

   If not, what was unclear? ________________________________

   ____

4. Do you think the material presented during this training session will be useful to you in your work? ____Yes ____No

5. To what extent did reproduced materials give you aid in understanding this session? ________None ________Some ________Much

6. Are there any additional topics which should have been covered during this training session? ____Yes ____No If Yes, what are they?

   ____

   ____

   ____

7. If you could change this training session, what would you do? ________

   ____

   ____

   ____

FORM 3

RUTLAND CENTER VISITOR QUESTIONNAIRE

Description:

A two-page form requesting information about each visitor and his perceptions concerning Rutland Center and its program.

Directions:

Each visitor is requested to complete this questionnaire at the conclusion of his visit.

Use:

This form provides a way of accounting for the number of visitors and a summary of their comments for quarterly and end of year reporting.

FORM 3
(Continued)
RUTLAND CENTER VISITOR QUESTIONNAIRE

Name ______________________ Date ______________________

Time Spent at Rutland Center ______________

1. How did you hear of Rutland Center?

2. What group or agency do you represent?

   Location?

3. What kind of information did you hope to obtain by coming?

   Did you, in fact, obtain this information?

4. What is your general impression of Rutland Center?

   Are there any suggestions you have regarding Rutland Center?

5. If you are from an agency, did you see any techniques here which you plan to employ in your own set-up?

   If yes, what?

6. With whom did you speak?

   ____Project Director
   ____Clinic Director
   ____Psychiatrist
   ____Psychologist
   ____Teacher
   ____Secretary
   ____Coordinator of Liaison and Field Services
   ____Coordinator of Psychoeducational Services
   ____Social Worker
   ____Evaluator
   ____Other (specify)________________

7. Through what source did you receive information prior to your visit here?

   ______Rutland Center Brochure
   ______Newspaper Article
   ______Personal Communication
   ______Other

FORM 3

(Continued)

8. If you observed the children, were the activities here at Rutland Center different from what you expected?

9. Please make other comments.

FORM 4

EVALUATION QUESTIONS FOR STAFF

A. Evaluation in General

1. Are you being provided with a useable service?
2. Are you being over-burdened by evaluation forms?
3. Is the evaluation team helpful?
4. Is the tail (evaluation) wagging the dog (project)?
5. Do you think the children (parents) are progressing?

   If so, how do you know? Can we assess and document this progression (or regression)? If so, how?

B. Service-to-Children

1. Would you like more assistance in using the current evaluation forms?
2. Are data from forms available to you? Too late?
3. How about the RFCL?
4. How do you use data from the RFCL?
5. How about the RORF? Completing the form?
6. How do you use data from the RORF?
7. How about the SWAN?
8. How do you use data from the SWAN?

FORM 4
(continued)

9. Any suggestions for improving the forms and/or use of the forms?

10. Any suggestions for other forms?

11. In general, are the data useful? Too much data? Too little data?

C. Service-to-Parents

1. How about the evaluation of the parent program?

2. Do you concern yourself with the Developmental Therapy objectives for home use?

3. Are you "getting to" the parents?

D. Other

1. What about the "team" approach?

2. What about the 10-week "change-over"?

3. Does the "staff-feedback" form provide you with ample opportunity to express your concerns?

FORM 5
INITIAL REFERRAL AND REQUEST FOR SERVICE

RUTLAND CENTER
685 Pope Street
Athens, Georgia

CHILD: ______ Date of Request: ______

PARENTS: ______ Date of Birth: ______

ADDRESS: ______ Present Age: ______

______ Phone: ______

School Attending: ______ Grade in School: ______

Referred by: ______ Phone: ______

Position: ______

Address: ______ By: Letter ______
Telephone ______
______ Person ______

TYPE OF SERVICE REQUESTED: ______

Presenting Problem: ______

Other agencies involved with child: ______

Additional Information: ______

Disposition: ______

Signature of Parent ______

Referral Received by: ______

FORM 6

INITIAL INTAKE INFORMATION

Date: ____________ Previous Treatment: ______________________________ (34)
Source of Referral: ____

Name: __________________ Case #: ________ Sex: ________ (7) ________ (8)

Birthdate: ____________ (9-14) CA on Intake: ______ (15-18) School: ________
mo. day yr.

Grade placement at referral: _____ (19-20) Teacher: ____________________

Address: __________________ County: __________ (21) Phone: __________

Child's birth weight: ______ # Sat up: ________ mo. Walked: ________ mo.

Toilet Trained: ________________ Talked: ______________ mo.

Marital Status: ________________________ (22)

Father: ____________________________ Date of Birth: ________________

Last grade completed in school: __________ (23-24) Occupation: ______________

Approx. Monthly Income: ____________ Business Address: ________________

Phone: ________________

Mother: ____________________________ Date of Birth: ________________

Last grade completed in school: __________ (23-24) Occupation: ______________

Approx. Monthly Income: ______________ Business Address: ________________

Phone: ________________

Brothers and Sisters:
Name ____________ Age ______ Grade ________
Name ____________ Age ______ Grade ________
Name ____________ Age ______ Grade ________
Name ____________ Age ______ Grade ________

#children in family: _____ (27-28) Child's position in family: ___ (29-30)

Anyone else living in home: ______________
Computed SES: ____________________ (31)
Computed Income Level: ______________ (32)
Computed Occupational Level: __________ (33)

IV-A Eligibility:
County ____________
Model Cities ________
Income ____________
Not eligible ________

I hereby authorize the Rutland Center to release information to appropriate professional agencies and individuals regarding ____________________.

____
Witness

____
Signature

____
Relationship to **Referred** child

FORM 7

RUTLAND CENTER
685 and 698 N. Pope St.
Athens, Georgia
(404) 549-3030
Second Revision

PART I
REFERRAL FORM CHECK LIST

CHILD'S NAME: ______________________________

Age: ______________ Birthdate: ______________
(month) (day) (year)

Grade: __________ School: ______________________

County: ______________________

School System ______________________

Date: ______________________

Person Completing Checklist: ______________________

Position: ______________________

Address: ______________________

Rutland Center Staff Contact Person:

______________________ Date: ______________

TYPE OF CHECKLIST: (Circle)

(1) INTAKE

(2) TERMINATION

(3) TRACKING

(4) OTHER: ______________

Directions: Mark problems which you have noticed in school, playground, home, etc. If a problem applies to the child, circle the appropriate number indicating the immediacy of the problem. IF A PROBLEM IS NOT NOTICED, OR NOT A PROBLEM, circle the number indicating this. Use the space for comment if there is something related to a problem which should be noted. Mark all items.

PROBLEMS	High Priority Problem (1)	Still High Priority Problem But Showing Improvement (2)	Low Priority Problem (3)	Still Low Priority Problem But showing Improvement (4)	Not A Problem Or Not Noticed (5)
BEHAVIOR					
1. Attendance problem (excessive absences, leaves school) Comment:	1	2	3	4	5
2. Demands excessive attention Comment:	1	2	3	4	5
3. Short attention span, unable to concentrate Comment:	1	2	3	4	5
4. Distractability Comment:	1	2	3	4	5
5. Lacks motivation, apathetic, lazy, lacks interest Comment:	1	2	3	4	5
6. Forgetful, does not retain Comment:	1	2	3	4	5
7. Restless/overactive Comment:	1	2	3	4	5
8. Perseveration (repetitive behavior) Comment:	1	2	3	4	5
9. Ritualistic, unusual behavior Comment:	1	2	3	4	5

1. High Priority Problem
2. Still High Priority Problem But Showing Improvement
3. Low Priority Problem
4. Still Low Priority Problem But Showing Improvement
5. Not a Problem or Not Noticed

BEHAVIOR CONT.

10. Resistant to discipline, directions, and/or structure, impertinent, defiant, resentful, uncooperative, negative 1 2 3 4 5
Comment:

11. Aggressive toward children 1 2 3 4 5
Comment:

12. Aggressive toward property, rules 1 2 3 4 5
Comment:

13. Self-aggressive or self-derogatory, physical abuse of self 1 2 3 4 5
Comment:

14. Does not complete tasks, careless, unorganized approach to assignments 1 2 3 4 5
Comment

15. Lacks comprehension of assigments 1 2 3 4 5
Comments:

16. Does not follow directions 1 2 3 4 5
Comment:

17. Masturbation 1 2 3 4 5
Comment:

18. Sexual aggression, exhibitionism 1 2 3 4 5
Comment:

19. Crying spells 1 2 3 4 5
Comment:

20. Easily frustrated 1 2 3 4 5
Comment:

21. Silliness 1 2 3 4 5
Comment:

22. Lacks confidence, fears failure 1 2 3 4 5
Comment:

23. Seeks failure for attention 1 2 3 4 5
Comment:

24. Temper tantrums 1 2 3 4 5
Comment:

1. High Priority Problem
2. Still High Priority Problem But Showing Improvement
3. Low Priority Problem
4. Still Low Priority Problem But Showing Improvement
5. Not a Problem or Not Noticed

COMMUNICATION

1. Immature behavior, verbal and/or nonverbal 1 2 3 4 5
Comment:

2. Unusual language content (bizarre, strange, fearful, ritualistic, jargon, fantasy) 1 2 3 4 5
Comment:

3. Speech problem: (check type) 1 2 3 4 5
a. rate_____
b. articulation___
c. stuttering____
d. voice problems___
e. no speech____
Comment:

4. Talks excessively 1 2 3 4 5
Comment:

5. Listening difficulties/difficulty comprehending 1 2 3 4 5
Comment:

6. Unable to express feelings appropriately 1 2 3 4 5
Comment:

7. Obscene language, cursing, sex talk 1 2 3 4 5
Comment:

8. Untruthfulness 1 2 3 4 5
Comment:

9. Moodiness, overly sensitive, sad, irritability 1 2 3 4 5
Comment:

10. Regressive behavior: verbal and/or nonverbal 1 2 3 4 5
Comment:

11. Physical complaints 1 2 3 4 5
Comment:

12. Repeats unnecessarily 1 2 3 4 5
Comment:

13. Echoes others' speech 1 2 3 4 5
Comment:

14. Avoids eye contact 1 2 3 4 5
Comment:

1. High Priority Problem
2. Still High Priority Problem but Showing Improvement
3. Low Priority Problem
4. Still Low Priority Problem But Showing Improvement
5. Not a Problem or Not Noticed

SOCIALIZATION

1. Lack of self-help skills: (check type) a. feeding_____ b. dressing_____ c. toileting _____ d. general hygiene_____ e. other___________	1	2	3	4	5
2. Tends to avoid participating with children in groups Comment:	1	2	3	4	5
3. Tends to avoid adults Comment:	1	2	3	4	5
4. Daydreams, unaware Comment:	1	2	3	4	5
5. Avoids difficult or new situations Comment:	1	2	3	4	5
6. Irresponsible Comment:	1	2	3	4	5
7. Tries to control others (critical of others, influences others' behavior, manipulative) Comment:	1	2	3	4	5
8. Stealing Comment:	1	2	3	4	5
9. Suspicious (distrusts or blames others excessively) Comment:	1	2	3	4	5
10. Jealous (possessive, selfish) Comment:	1	2	3	4	5

1. High Priority Problem
2. Still High Priority Problem But Showing Improvement
3. Low Priority Problem
4. Still Low Priority Problem But Showing Improvement
5. Not a Problem or Not Noticed

AREAS OF ACADEMIC OR PRE-ACADEMIC DIFFICULTIES

Report any known or estimated achievement levels under comment:

1. Reading or reading readiness Comment:	1	2	3	4	5
2. Arithmetic or number concepts Comment:	1	2	3	4	5
3. Writing (penmanship) or hand coordination Comment:	1	2	3	4	5
4. Verbal communication Comment:	1	2	3	4	5
5. Spelling Comment:	1	2	3	4	5
6. Written communication Comment:	1	2	3	4	5

Other comments:

A. Supplementary Information

	Problem	Possible Problem	Not Noticed or Not A Problem	Comments
Hearing Acuity				
Visual Acuity				
Clumsiness				
Seizures (manifest)				
Seizures (suspected)				
Academic Retardation				
Intellectual Retardation				
Slow Learner				
Lacks school readiness skills				
Lacks age appropriate social and cultural skills				
Illness or Physical Disability (Specify ______________________________)				

B. Please comment or note any academic, behavioral or personality strengths. For example -- Behavior: shows helpfulness to others, excels in sports; Communication responds to praise, offers ideas freely; Socialization: shares, likes people; Academic or Pre-Academic: excels in academic and/or creative activities.

FORM 8

PROCEDURES FOR ADMINSTERING THE REFERRAL FROM CHECKLIST (RFCL) TO PARENTS OR TEACHERS

The Purpose of the RFCL

The RFCL is a list of behavior problems classified within four major developmental areas of the growing child: Behavior, Communication, Socialization, and School Readiness Skills. The RFCL is composed of two parts. Part I, pages 1-7, is composed of 54 problems aligned in the four curriculum areas, Behavior, Communication, Socialization, Remediation, on a five-point rating scale from "High Priority Problem" to "Not Noticed or Not a Problem". There is also a Supplementary Information section concerned with other particular problems and a section to note strengths or special abilities.

Part II is numbered 1-1 to 1-4 and is composed of various sections for professional staff to complete: Perceptual Difficulties, Defense Mechanisms, Psychodynamic Summary, Tentative Classification, and View of Problem including a rating of severity and prognosis. Only Part I is used with parents and with classroom teachers. The Rutland Center staff completes Parts I and II.

It is of interest to most teachers and parents filling out this form to know that these behavior items were primarily selected from problems classroom teachers and parents identified. These referrals were collected over a three year period.

Information from the RFCL will aid the center staff in obtaining a composite picture of the child's problems as perceived through the eyes of several individuals. It will also provide a pre-post measure of treatment effectiveness, determining what changes in the child's problem behaviors have been made at the end of the treatment period.

Directions for Administering the RFCL*

Introduce the RFCL to parents or teachers. Be sure they understand the purpose of the RFCL as described above. Directions to be given to the parents or teachers before filling out the Referral Form Checklist follow. These directions may be paraphrased.

> "This checklist includes a wide range of children's behaviors. It has been found that most children's problems are in behavior, socialization, communication and (pre) academics. Many of the items will not apply to your child. The purpose of this is to find out what the major problems are. The important thing is to identify the problems that you feel are important to the child's situation."
>
> If you consider the item a big problem, circle number one. If it is not a problem or you have not noticed, circle number five. If it is a big problem but getting

---

*These directions may be paraphrased and are used when obtaining an RFCL from teachers or from parents.

> better, circle number two; and if it is a small problem, circle number three. Number four is circled if it is a small problem but showing improvement. It is important to mark each item in one of these ways.
>
> If there are any problems which you have observed and are not included in this checklist, please let me know. If I can clear up any confusing terms on this checklist, please ask."

After the teacher or parent has completed the form, look through it to make sure that all of the items have been rated.

Take any notes necessary concerning the session. The completed Referral Form Checklist provides a good view of the child from the parents' or the classroom teacher's standpoint, in combination with observation and general information gathering.

If both parents, or several teachers, are present the RFCL may be completed through consensus.

Regarding the question of how much direction should be given in connection with clarification of items on the Referral Form Checklist, the following guidelines should be used. (Notes should be made if there is inconsistency between what the parent or classroom teacher has said and what is actually marked.)

1. Person indicates the child is doing x, y, and z.
2. However, the Referral Form Checklist is not marked in such a way that x, y, and z show up as problems.
3. Make a note of the problem as the person describes it.
4. Verify that the behavior is a problem.
5. Verify the degree of the problem.

6. Suggest classification of the problem on the Referral Form Checklist.

7. Verify agreement of the classification (if the person does not agree with the suggested classification, accept this, but later make a notation of what transpired in the conversation).

When the Referral Is Not From the School

Obtain an appointment with the classroom teacher through the principal. This call should serve as a means to inform the school of the referral and to request their assistance.

Should conflicting points of view exist regarding the need for referral it should be indicated that this information is helpful to know and further elaboration of this point of view would be beneficial in helping to learn about every facet of the child's life.

With the classroom teacher, ask for a description of the child in the classroom: Briefly explore behavior, socialization, communication, and academics. Introduce the Referral Form Checklist to the teacher as described previously.

Should you feel the need to verify any information, question more specifically certain classroom reactions that usually elicit those problems stated on the Initial Referral Form. This should be done briefly, and without relaying confidential parental information given at the time of initial referral.

Let the teacher know that it is of great help in planning a child's program to know how he has adjusted in school. Assure her that results obtained from testing will be reported to her in a future Educational Planning Conference if she so desires.

FORM 9

PART II
REFERRAL FORM CHECK LIST
SUPPLEMENTARY PAGE
(Second Revision)

1. Sections A through D to be completed by psychiatrist, psychologist, and Center teacher.

A. Perceptual and motor difficulties related to learning tasks

	Problem	Possible Problem	No Problem	Comments
Visual perception difficulties	___	___	___	___
Auditory perception difficulties	___	___	___	___
Eye-hand coordination problems	___	___	___	___
Left-right confusion	___	___	___	___
Gross motor difficulties	___	___	___	___
Fine motor difficulties	___	___	___	___

1. High Priority Problem
2. Still High Priority Problem But Showing Improvement
3. Low Priority Problem
4. Still Low Priority Problem But Showing Improvement
5. Not a Problem Or Not Noticed

B. Defense Mechanisms

Regression 1 2 3 4 5
Comment:

Intellectualization 1 2 3 4 5
Comment:

Projection 1 2 3 4 5
Comment:

Compulsion 1 2 3 4 5
Comment:

Identification 1 2 3 4 5
Comment:

Withdrawal 1 2 3 4 5
Comment:

Simple denial 1 2 3 4 5
Comment:

Reaction formation 1 2 3 4 5
Comment:

Rationalization 1 2 3 4 5
Comment:

Compensation 1 2 3 4 5
Comment:

Sublimation 1 2 3 4 5
Comment:

Displacement 1 2 3 4 5
Comment:

Hypochondria 1 2 3 4 5
Comment:

C. Psychodynamic Summary

Appearance	1	2	3	4	5
Comment:	meticulous				slovenly
Anxiety	1	2	3	4	5
Comment:	little				excessive
Self-concept	1	2	3	4	5
Comment:	high				low
Ego-strenght	1	2	3	4	5
Comment:	high				low
Affect					
Comment:	1	2	3	4	5
	appropriate				not appropriate
Super-ego	1	2	3	4	5
Comment:	under developed				over developed

D. Tentative Classification for description of major handicapping conditions. If more than one classification is suggested, rate in order of treatment priority.

Suspected brain damage ______________________________

Suspected schizophrenia ______________________________

Suspected autism ______________________________

Suspected aggressive, hostile ______________________________

Suspected delayed development ______________________________

Suspected socioeconomic deprivation ______________________________

Suspected learning disability ______________________________

Suspected obsessive-compulsive ______________________________

Suspected character disorder ______________________________

Suspected reactive disorder ______________________________

Other ______________________________

E. View of Problem

	Level of Problem mild severe	Prognosis good poor
BEHAVIOR	1 2 3 4 5	1 2 3 4 5
COMMUNICATION	1 2 3 4 5	1 2 3 4 5
SOCIALIZATION	1 2 3 4 5	1 2 3 4 5
REMEDIATION	1 2 3 4 5	1 2 3 4 5
OVERALL	1 2 3 4 5	1 2 3 4 5

PSYCHIATRIC EVALUATION

NAME: AGE: DATE: PSYCHIATRIST:

Problem	Mild		Moderate		Severe	Not a Problem Or Not Noticed
Tandum walking Comment:	1	2	3	4	5	____________
Hopping Comment:	1	2	3	4	5	____________
Skipping Comment:	1	2	3	4	5	____________
Difficulty in rapid alternating hand movement Comment:	1	2	3	4	5	____________
Difficulty in finger to finger apposition Comment:	1	2	3	4	5	____________
Difficulty in finger to nose apposition Comment:	1	2	3	4	5	____________
Tremor Comment:	1	2	3	4	5	____________
Athetoid Movements Comment:	1	2	3	4	5	____________
Spastic Movements Comments:	1	2	3	4	5	____________
Nystagmus Comment:	1	2	3	4	5	____________
Left-Right Confusion Comment:	1	2	3	4	5	____________

FORM 10

Rutland Center
698 N. Pope St.
Athens, Georgia 30601
404-549-3030
July 14, 1972

DEFINITIONS FOR REFERRAL FORM CHECKLIST PROBLEMS

(BEHAVIOR)

	Problem	
1.	Attendance problem (excessive absences, leaves school)	Exceeding the usual or normal amount of school absences
2.	Demands excessive attention	Requiring an extreme amount of attention
3.	Short attention span, unable to concentrate	Not able to pay attention long enough to accomplish a task; inability to bring into the focus of attention
4.	Distractability	An undesirable shift of attention; easily drawn to extraneous stimuli
5.	Lacks motivation, apathetic, lazy, lacks interest	Deficit in the process of initiating, sustaining, and directing one's activities; absence of feeling and emotion in situations usually calling forth such reactions
6.	Forgetful, does not retain	Inability to recall or recognize what was learned at an earlier time
7.	Restless/overactive	Tendency toward aimless and constantly changing movements
8.	Perseveration (repetitive behavior)	Persistent repetition of the same thought or activity
9.	Ritualistic, unusual behavior	Stereotyped actions directed toward meticulous details; strange activities not ordinarily seen in children
10.	Resistent to discipline, directions, and/or structure, impertinent, defiant, resentful, uncooperative, negative	Not amenable to training or control within due or proper bounds; disagreeable
11.	Aggressive toward children	Hostile act or word directed toward a child consciously or unconsciously designed to hurt or damage

	Problem	
12.	Aggressive toward property, rules	Hostile, act or word directed toward objects or rules; distructive
13.	Self-aggressive or self-derogatory, physical abuse of self	Hostile act or word turned inward toward the self
14.	Does not complete tasks, careless, unorganized approach to tasks	Failure to finish work, disordered approach to tasks
15.	Lacks comprehension of assignments	Failure to understand, especially to understand what a symbol refers to or what an object of thought implies
16.	Does not follow directions	Failure to follow through with appropriate or desired behavior after verbal or written request
17.	Masturbation	Self-stimulation of genitals
18.	Sexual aggression, exhibitionism	Hostile act involving sexual overtones; tendency to expose sex parts under inappropriate circumstances
19.	Crying spells	Extended periods of crying
20.	Easily frustrated	Upset easily when need or desire is thwarted
21.	Silliness	Foolish; Inappropriately childish; ridiculous absurd behavior
22.	Lacks confidence, fears failure	Unsure of self; afraid to try
23.	Seeks failure for attention	Performs incorrectly or fails to do a task in order to be noticed
24.	Temper tantrums	Irrational, violent anger reaction

(COMMUNICATION)

	Problem	
1.	Immature behavior, verbal and/or nonverbal	That behavior which is inappropriate for the child's level of chronological development
2.	Unusual language content (bizarre, strange, fearful, ritualistic, jargon, fantasy)	Language content which is strikingly out of the ordinary in an odd or eccentric way
3a.	Speech problem: rate	Speech that is unusually fast or slow
3b.	Speech problem: articulation	Difficulty in producing speech sounds

(COMMUNICATION)

	Problem	
3c.	Speech problem: stuttering	Difficulty in speech rhythm, characterized by blocking and repetition of sounds, words, or phrases
3d.	Speech problem: voice	Speech that is unusually loud, soft, weak, or scratchy
3e.	Speech problem: no speech	Absence of speech; has speech but chooses not to speak in ordinary situation requiring speech
4.	Talks excessively	Frequency of verbalizing which exceeds what is usual or normal
5.	Listening difficulties/ difficulty comprehending	Trouble listening or understanding what is being said
6.	Unable to express feelings appropriately	Difficulty in conveying emotions suitably
7.	Obscene language, cursing, sex talk	Spoken language which violates the social conventions of fitness with respect to sexual or other bodily functions
8.	Untruthfulness	Deliberately presenting things or events not as they actually are in reality
9.	Moodiness, overly sensitive, sad, irritability	Temperamental; subject to depression; unhappy; conveys emotions and feelings beyond the ordinary extent
10.	Regressive behavior: verbal and/or non-verbal	A return to earlier and less mature behavior
11.	Physical complaints	Talks of bodily ailments
12.	Repeats unnecessarily	Repetition of own or other's words or phrases with intent
13.	Echoes others' speech	Repetition of words and phrases of another without intent to convey meaning
14.	Avoids eye contact	Evades looking directly into the face of another

(SOCIALIZATION)

	Problem	
1a.	Lack of self-help skills: feeding	Unable to feed self
1b.	Lack of self-help skills: dressing	Unable to dress self

	Problem	
1c.	Lack of self-help skills: toileting	Unable to conduct toilet activities unaided
1d.	Lack of self-help skills: general hygiene	Unable to carry out practices conducive to health such as washing hands, brushing teeth
2.	Tends to avoid participating with children in groups	Stays apart from other children
3.	Tends to avoid adults	Stays away from adults
4.	Daydreams, unaware	Idle thinking; does not seem to notice surroundings and happenings
5.	Avoids difficult or new situations	Stays away from problems, hard tasks or unfamiliar circumstances
6.	Irresponsible	Unreliable; not trustworthy
7.	Tries to control others (critical of others, influences others' behavior, manipulative)	Attempt to manage others to one's own advantage
8.	Stealing	Taking the property of another
9.	Suspicious (distrusts or blames others excessively)	Social attitude characterized by doubt of the sincerity or actions of another
10.	Jealous (possessive, selfish)	Apprehensive of the loss of another's exclusive devotion; vigilant in guarding a possession

(ACADEMICS)

Problem	
1. Reading or reading readiness	Ability to demonstrate knowledge of basic reading or pre-reading processes, commensurate with a childs' ability, developmental level, such as skills in the areas of word recognition and comprehension, during listening, oral and silent reading.
2. Arithmetic or Number concepts	Ability to demonstrate knowledge of basic arithmatical processes within his mental age.
3. Writing (penmanship - the ability to legibly or hand coordination)	The ability to legibly reproduce language symbols comparable with a child's expected developmental age.
4. Verbal Communication	Ability to communicate ones feeling's and ideas through spoken words.
5. Spelling	Ability to remember and cognitively integrate visual and/or auditory symbols, into words.
6. Written communication	Ability to use written symbols to effectively express ideas.

FORM 11

REFERRAL FORM CHECKLIST
PROFILE ANALYSIS PLOT (PAP)

Description:

A two-page form providing for marking all items on the RFCL by all persons completing the RFCL. Space is allotted for every possible response to all the various scales for both parts of the RFCL.

Directions:

Each person completing the RFCL is given a symbol:

Psychologist = □
Educational Evaluator = O
Parent = \
Classroom Teacher = /
Psychiatrist = |

Each person's responses are then marked for each item. If all four persons marked Behavior problem No. 1 as "high priority" the following would appear:

Behavior: 1
2 -
3 -
4 -
5 -
1

(Many other sets of markings are of course possible). Thus each person's response to each item is marked for all sections of the RFCL. The entire RFCL is completed by the person marking at one time. The individual performing the summarization does one person's RFCL all the way through and then marks another checklist. The marker repeats this process as many times as there are checklists for a child.

Use:

Presentation of problem information gained from all adult sources concerned with the child is made to the individuals present at staffing. The PAP presents a picture of agreements and disagreements with respect to perceptions of child's problems by those completing the RFCL.

FORM 11 (Continued)

REFERRAL FORM CHECKLIST-PROFILE ANALYSIS PLOT

CHILD'S NAME____________________ DATE______ EVALUATOR________________

1. Behavior

1. -
2. -
3. -
4. -
5. -

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24

II. Communication:

1. - - - - - - - - - - - - - -
2. - - - - - - - - - - - - - -
3. - - - - - - - - - - - - - -
4. - - - - - - - - - - - - - -
5. - - - - - - - - - - - - - -

1 2 3 4 5 6 7 8 9 10 11 12 13 14

(a,b,c,d,e)

III. Socialization:

1. - - - - - - - - - -
2. - - - - - - - - - -
3. - - - - - - - - - -
4. - - - - - - - - - -
5. - - - - - - - - - -

1 2 3 4 5 6 7 8 9 10

(a,b,c,d,e)

IV. Areas of Academic or Pre-Academic Difficulties:

1. - - - - - -
2. - - - - - -
3. - - - - - -
4. - - - - - -
5. - - - - - -

1 2 3 4 5 6

FORM 12

REFERRAL FORM CHECKLIST (RFCL)
BAR GRAPH

Description:

A series of bars, one for each problem marked "1" or "2" by one or more persons completing the RFCL. (This concerns only the 54 problems listed in the RFCL under the four curriculum areas: Behavior, Communication, Socialization, and Remediation, Pages 1-6). The length of the bar indicates the number of people marking the problem "1" or "2".

S = Staff (psychologist and/or educational evaluator, and/or psychiatrist, or any combination thereof)

P = Parent

T = Classroom Teacher

Directions:

For each problem listed on the first sheet of the RFCL Profile Analysis Plot (24 for behavior, 14 for communication, 10 for socialization, and 6 for academic or pre-academic difficulties) list, in order, those problems rated as "1" or "2" by rater(s) in extreme left column and by number and name. List in blocks by curriculum areas. Then note the number of raters marking 1 or 2 and allot 5 horizontal spaces for each person (1 person is 5 spaces, 2 is 10 spaces, etc.
In the middle column draw the bars of the correct number of spaces. In third column, list who marked problem as 1 or 2.

Use:

This form is used along with the Profile Analysis Plot in depicting problem behaviors of a child such that a staffing decision can be reached regarding placement in program or referral to another agency.

FORM 12 (Continued)
RFCL BAR GRAPH

	No. marking 1's & 2's					WHO MARKED IT?
	1	2	3	4	5	

S = STAFF / T = TEACHER / P= PARENT

FORM 13
RUTLAND CENTER
EDUCATIONAL ASSESSMENT

NAME: ______________________ Age at testing: ___yrs. ___mos.
EVALUATOR: ______________________ School: ______________________
DATE: ____________ Grade: ____________
OVERALL TEST BEHAVIOR: ______________________________
____
____

I. General Developmental Level: median score _____ years (on page 1 only)*

Tests Used	Result	Comments
*Ilg and Ames Paper and Pencil Tests		
Name	______yr.*	______
Date	______yr.*	______
Address	______yr.*	______
D.O.B.	______yr.*	______
Numbers	______yr.*	______
Manuscript/ cursive?	______*	______
Left/right handed?	______*	______
*Ilg and Ames Copy Forms		
Circle	______yr.*	______
Square	______yr.*	______
Triangle	______yr.*	______
Cross	______yr.*	______
Div. rectan.	______yr.*	______
Diamond (Horz.)	______yr.*	______
(Vert.)	______yr.*	______
(Optional: imitate examiner)	______	______
(Optional: from memory)	______	______
Directionality difficulty?	Yes___ No___	______
Line quality?	______	______
Left or right handed?	______	______
*Peabody Picture Vocabulary Test	(MA) ___yrs. ___mos.	______
*Goodenough Draw-A-Person	Drawing Age	
Self	(DA) ___yrs. ___mos.	______
Others	(DA) ___yrs. ___mos.	______
Other Developmental Tests (Tests must be named below)		
______	______	______
______	______	______
______	______	______

*Data must be recorded. Mark CND if child Could Not Do.

Form 13
(Continued)
Page 2

II. Arithmetic - Overall Instructional Level: PS, K, 1, 2, 3, 4, 5 (circle one)*

	Process	Result	Comments
PS	rote counting to:	______	______
	couting one-to-one to:	______	______
K	recognizes objects in groups without counting:	3:___ 6:___	______
		5:___ 7:___	______
	counting by fives to:	______	______
	counting by tens to:	______	______
	writing numbers to:	______	______
1	adding sums (1-5):	______	______
	adding sums (6-10):	______	______
	subtracting (from 5 or less):	______	______
	subtracting (from 10 or less):	______	______
2	adding sums (above 10) without carrying:	______	______
3	adding sums (above 10) with carrying:	______	______
	subtracting with borrowing:	______	______
4	multiplication	______	______
	division	______	______
	place value	______	______
5	writing fractions from dictation	______	______
	operations with fractions	______	______
	understands modern math vocabulary	Yes___ No___	______
	understands processes behind computations	Yes___ No___	______

Suggested Instructional Approach: ____

____

____

____

*Data must be recorded.

Form 13
(Continued)
Page 3

III. Sensory Motor Functions: age appropriate ___, below age level ___, significant deficit ___ (check one)*

Process	Tests Used	Result	Comments
A. eye-hand coordination			
***coloring	Petersen Cube		
***peg board			
***scissors	Petersen Cube		
***pasting	Petersen Cube		
***bead stringing	Petersen Cube		
***stacking blocks	Gesell		
eye-hand(pencil/paper)	Frostig Sheets/ other		
figure ground	Frostig Sheets/ other		
form constancy	Frostig Sheets/ other		
position in space	Frostig Sheets/ other		
spatial relationships	Frostig Sheets/ other		
B. gross motor coordination			
walking tape	Petersen I	forw. | backw.	
		right | left	
throwing/catching	Petersen I		
skipping	Petersen I		
hopping	Petersen I		
stairs	Observation		
gait	Observation		
dominance		rt. mixed lt. *	
C. Memory			
short term: concrete	3 objects		
short term: verbal	3 word phrases nonsense syl.		
short term: numbers	3 numbers		
long term:	Binet commands		
long term:	other		
D. Rate of Learning	Durrell Subtest		
	Other		
E. Tactile Discrimination	fruit (object) in bag		

Suggested Learning Approach and Needed Activities: ______________________

*Data must be recorded.
***Preschool child only.

IV. Reading - Overall Instructional Level: PS, K, 1, 2, 3, 4, 5 (Circle one)*

**1. Durrell Analysis of Reading Difficulty

Subtest	Result	Comments
Listening Comprehension	___ gr. Level	
Silent Reading	___ gr. Level	
Work Recognition: Flash	___ gr. Level	
Analysis	___ gr. Level	
Letters:	(Letters mastered)	
Naming		
Identifying by sounds		
Matching		
Writing		
Hearing Sounds in Words		
Initial Consonants		
Final Consonants		
Mid-sounds		
Blends and Digraphs		
Phonics Spelling	___ gr. Level	

**2. PreAcademic

Process	Tests Used	Result		Comments
Classifying Objectives	Petersen 14 or DLM			
Picture Associations	Petersen or DLM			
Picture Concepts				
Big/Little	Milton Bradley flannel "opposites"			
Over/Under				
Up/Down				
3 card sequences	DLM			
Similarities:				
matching objects				
matching colors				
Similiarities/differences	Petersen 9(a)(b)			
Auditory memory	Petersen 11			
Auditory discrimination	Petersen 10			
Color recognition		named	pointed	
red				
blue				
yellow				
green				
black				
pink				
orange				
brown				
purple				

SUGGESTED INSTRUCTIONAL APPROACH: ______________________________

*Data must be recorded

**Give only one or the other, except with children making transition from preacademic to academic.

V. Motivational, Attitudinal, Personal/Social Functions

Self Concept	(Choose one)	
	Bowers Happy/Sad	
	A Book About Me	______
	Informal Talk	______
	Informal Pictures	______
	Mooney P. C.L.	______
School Attitudes	(Choose one)	
	Informal Discus.	______
	Bowers Class Pictures	______
	Informal Pictures	______
	Social Partic. C.L.	______
	A Book About Me	______
Family Attitudes	(Choose one)	
	Family Drawings	______
	Informal Discus.	______
	Informal Play (With puppets)	______

What are Child~~'s~~ Baisc Needs as You See Them?: ______

Attention Span ______
Task Orientation ______
Frustation Tolerance ______
Response to Praise ______
Response to Failure ______
Speech Quality ______
Language Content ______
Approach Used to Motivate ______

Levels in
Developmental Therapy

Area	Level
Behavior	______ *
Communication	______ *
Socialization	______ *
Academic	______ *

ADDITIONAL RECOMMENDATIONS AND COMMENTS: (Use other side if needed)

---

*Data must be recorded

FORM 14

RUTLAND CENTER

EDUCATIONAL ASSESSMENT

GUIDELINES

Purposes of the Educational Assessment

The educational assessment of a referred child is conducted as one part of an information gathering process designed to determine the child's current and potential modes of functioning at school, home, neighborhood, in peer groups, with adults, in formal test-like situations, with informal play materials, with schoolwork, and with creative materials.

The educational diagnostician conducts the assessment in a manner suggesting an informal school (or preschool) program.

Both standaradized, norm referenced data and informal child referenced information are obtained for as full a picture of the child as possible.

Specific Objectives

The educational assessment of a child has six specific objectives:

1. To determine A GENERAL DEVELOPMENTAL LEVEL as represented by specific performance in tasks requiring receptive vocabulary, visual-motor, and visual-memory-motor skills, organizational maturity, basic mastery of symbols, and self help skills.
2. To determine A GENERAL INSTRUCTIONAL LEVEL FOR ARITHMETIC and to identify specific numerical concepts and processes already mastered and those areas suggesting deficits.
3. To determine THE ADEQUACY OF SENSORY MOTOR FUNCTIONS to meet requirements of chronological age norms, specifically eye-hand coordination, visual-perception functions, memory, rate of learning, preferred mode of learning, and gross motor skills.
4. To determine A GENERAL INSTRUCTIONAL LEVEL FOR READING, specific reading processes mastered, and those areas indicating deficits.

5. To obtain INFORMATION REGARDING MOTIVATIONAL, ATTITUDINAL AND PERSONAL/SOCIAL FUNCTION with particular attention to self concept, school attitudes, family attitudes, and emotional-social needs.
6. To describe THE CHILD'S OVERALL PERFORMANCE IN BEHAVIOR, COMMUNICATION, SOCIALIZATION, AND ACADEMICS according to levels as outlined in Developmental Therapy.

These six objectives provide comprehensive information concerning a child's abilities as well as deficits. From this information an individualized psychoeducational program can be prepared with precision. Whether the child is enrolled subsequently in a therapeutic class at Rutland Center or is served in his regular school by his regular teacher, this material provides specific direction and entry points for his educational program.

The Educational Assessment Form

These six objectives for an educational assessment have been organized into a brief reporting form, RUTLAND CENTER EDUCATIONAL ASSESSMENT, found in the Appendix, FORM 13. This form eliminates the need for a typed narrative or a case report.

In using the educational assessment form, the educational diagnostician obtains a summary statement reflecting the overall level of a child for each specific objective. By further reporting specific processes and details of mastery or deficit, individual educational programs can be prepared for a child which accurately reflect his needs for each of the six objectives. Tests included on this form are not the only tests which might be used. IT IS THE PROCESS OR CONCEPT TO BE ASSESSED, NOT THE PARTICULAR TEST CHOOSEN, WHICH IS ESSENTIAL TO A FULL, RELEVANT EDUCATIONAL ASSESSMENT.

Substitute tasks or tests can be used for any item except those asterisked. Items with the asterisk are used in describing all children receiving educational assessments at the Center over a period of time and are general, not specific, in nature.

To accomplish the general and specific objectives for any educational assessment, the educational diagnostician is the person who makes the decisions concerning the most appropriate testing procedure, tests used, and order of presentation. However, the Rutland Center Educational Assessment form should be an aid in structuring the testing situation and subsequent reporting. The form was prepared in a sequence suitable for testing most children between the ages of 4 and 14 years. Care was given to begin with activities of a neutral and fairly non-threatening nature. A successful beginning seems essential for a child to respond freely to the educational diagnostician and to feel confident in the testing situation. The sequence of testing also varies the type of activity: paper and pencil tasks, communication tasks, motor activities, symbolic tasks, and interpersonal situations.

An educational assessment at Rutland Center, using the Educational Assessment form as guide, should be completed in 45 to 90 minutes. The information should be viewed as an introductory assessment from which specific plans for a child's program can be built. A number of very fine diagnostic tests have not been included due to the length of time required to administer such tests adequately, and because the information from such tests usually provides extensive assessment in a particular area of function.

Completion of the form, including recommendations, should be viewed as a program beginning, not an end in itself. During all phases of subsequent work with a child the information obtained at the initial assessment should be subject to scrutiny and question.

In summary, requirements for using the Educational Assessment form are:

1) All items with asterisks must be done.
2) The diagnostician must assess and report in each area designated by Roman Numerals, reporting mental age (MA), chronological age (CA), drawing age (DA), or grade level.
3) With every norm referenced test, it is important to conduct the test exactly as outlined in the test manual.
4) Additional tests may be used or substituted if desired, but these must be reported.
5) Educational diagnosticians should be thoroughly familiar with the Developmental Therapy Representative Objectives and be able to identify specific Developmental Therapy ob-

jectives the child has mastered and those he cannot accomplish in order to fill out the last portion of the Rutland Center Educational Assessment form.

Use of the RFCL

Immediately following the testing, the educational diagnostician fills out a Referral Form Check List (RFCL). Information from this form is used along with the results from the actual testing to make decisions at staffing concerning the child's placement.

The information gathered in the educational assessment, is used with parent interview information, psycholocical testing results, psychiatric evaluation, the Referral Form Checklist Profile (RFCL) and a report from a school visit. Together this information presents a composite description of the child's problems and his resources in four major categories of development: BEHAVIOR, COMMUNICATION, SOCIALIZATION, and (PRE) ACADEMICS.

This information is used by the Center staff to answer two major questions: (a) What is needed to assist this child in more successful adjustment to his home and school environments and (b) where can this assistance be obtained most effectively?

Specifically, the staff arrives at a series of recommendations for each child which include the following:

1. General recommendations for long term goals particularly related to developmental expectations.

2. Placement according to maturational sequences used in Developmental Therapy in each of the four areas of behavior, communication, socialization, and (pre) academics.

3. Specific recommendations regarding current problems and points of entry for therapeutic intervention.

4. Specific recommendations regarding methods, materials, and experiences needed.

5. Specific recommendations regarding enrollment at Rutland Center or alternative treatment resources.

6. Recommendations for type and amount of parent involvement.

7. Recommendations for type and amount of (pre) school involvement.

Following the staff review, a parent planning conference and an educational planning conference (with the (pre) school) are held to report testing results and recommendations. These conferences also are used for planning with parents and teachers specific ways to implement recommendations at home, school, and Center.

FORM 15

PSYCHOLOGICAL
Testing Report
Form
(for Evaluation Team)

Name: ______________________________

Date of Testing: ______________________

WISC	Perf. ____________	Verbal ______________	Full Scale ________
S.B.	C.A. _____________	M.A. _______________	I.Q. ___________
P.P.V.T.	C.A. _____________	M.A. _______________	I.Q. ___________

Columbia Mental Maturity Scale ______________________________________

Other: ___________________________

____

____

Psychologist

____

FORM 16

NAME OF CHILD: ____________________ DATE: ____________________

SUMMARY: SUPPLEMENTARY INFORMATION

A. Perceptual and motor dif.:	problem	possible problem	no problem
Visual perception	-	-	-
Auditory perception	-	-	-
Eye-hand coordination	-	-	-
Left-right	-	-	-
Cross motor	-	-	-
Fine motor	-	-	-

B. Defense Mechanisms:	1	2	3	4	5
Regression	-	-	-	-	-
Intellectualization	-	-	-	-	-
Projection	-	-	-	-	-
Compulsion	-	-	-	-	-
Identification	-	-	-	-	-
Withdrawal	-	-	-	-	-
Simple denial	-	-	-	-	-
Reaction formation	-	-	-	-	-
Rationalization	-	-	-	-	-
Compensation	-	-	-	-	-
Sublimation	-	-	-	-	-
Displacement	-	-	-	-	-
Hypochondria	-	-	-	-	-

C. Psychodynamic Summary:		1	2	3	4	5	
Appearance	(meticulous)	-	-	-	-	-	(slovenly)
Anxiety	(little)	-	-	-	-	-	(excessive)
Self-concept	(high)	-	-	-	-	-	(low)
Ego-strength	(high)	-	-	-	-	-	(low)
Affect	(appropriate)	-	-	-	--	-	(not appropriate)
Super-ego	(under developed)	-	-	-	-	-	(over developed)

D. Tentative Classification:

Suspected Brain Damage ___________
Suspected schizophrenia ___________
Suspected autism _________________
Suspected aggressive-hostile ______
Suspected delayed development _____
Suspected socioeconomic deprivation _______
Suspected learning disability _____
Suspected obsessive - compulsive _____
Suspected character disorder ______
Suspected reactive disorder _______
Other ________________________________

FORM 16
(Continued)

SUMMARY: SUPPLEMENTARY INFORMATION

General Information:	**Problem**	**Possible Problem**	**Not noticed or not a problem**
Hearing acuity	-	-	-
Visual acuity	-	-	-
Clumsiness	-	-	-
Seizures (manifest)	-	-	-
Seizures (suspected)	-	-	-
Academic retardation	-	-	-
Intellectual retardation	-	-	-
Slow learner	-	-	-
Lacks school readiness skills	-	-	-
Lacks age appropriate social and cultural skills	-	-	-
Illness or physical disability	-	-	-

E. View of Problem:

	Level of Problem					Prognosis				
	Mild				Severe	Good				Poor
	1	2	3	4	5	1	2	3	4	5
Behavior	-	-	-	-	-	-	-	-	-	-
Communication	-	-	-	-	-	-	-	-	-	-
Socialization	-	-	-	-	-	-	-	-	-	-
Remediation	-	-	-	-	-	-	-	-	-	-
Overall	-	-	-	-	-	-	-	-	-	-

Psychiatric:	Mild		Moderate		Severe
	1	2	3	4	5
Tandum	-	-	-	-	-
Hopping	-	-	-	-	-
Skipping	-	-	-	-	-
Alternating Hand Movement	-	-	-	-	-
Finger to Finger Appos.	-	-	-	-	-
Finger to nose Appos.	-	-	-	-	-
Tremor	-	-	-	-	-
Athetoid Movements	-	-	-	-	-
Spastic Movements	-	-	-	-	-
Nystagmus	-	-	-	-	-
Left-Rt. Confusion	-	-	-	-	-

FORM 17

RUTLAND CENTER
PSYCHOEDUCATIONAL TREATMENT SHEET

TO BE COMPLETED PRIOR TO STAFFING

Name: ____________________
Date of Birth ____________________
Age ____________________
Referral Source ____________________
School ____________________
Teacher ____________________
Date of Staffing ____________________

TESTING INFORMATION

Test Given	Examiner	Date
PSYCHOLOGICAL		
DUCATIONAL		
SYCHIATRIC		
.W. INTAKE		

TO BE COMPLETED AT STAFFING

Accepted: Yes _____ No _____
EPC School _____ Parent _____
School & Parent __________
Tent. Class. __________
Levels of obj: __________
Beh. __________
Comm. __________
Social. __________
Acad. __________
Class Placement
Level __________
Time __________
Team Capt. __________
Projected Term. __________
(Actual Term.) __________

STAFFING SUMMARY

ajor RFCL
roblems

ajor Home
ocus:

Level of Participation: Check one
Minimal _____
Intermittent _____
Extensive _____

ajor School
ocus:

(over)

FORM 17
(continued)

TREATMENT SHEET

Page 2

Clinical
Interpretations:

Recommendations:

FORM 18

DEVELOPMENTAL THERAPY CURRICULUM

REPRESENTATIVE OBJECTIVES

Behavior

Level 1 Behavior Goal - TO TRUST OWN BODY AND SKILLS

1. to be aware of sensations and to attend to environmental stimuli (through looking directly at object or person in situations using tactile, kinesthetic, visual, auditory, gustatory, and olfactory modalities.)

2. to attend to environmental stimuli (through continued looking at object, person, and sounds after initial stimulus-response has occurred; through sustained sitting in chair during required activity time)

3. to respond with motor behavior to single environmental stimulus: object, person, sound (Child gives correct motor or verbal response to the command, "Give me _______." No choices offered.)

4. to respond with motor and body responses to multiple environmental and verbal stimuli (through imitation "do this"; through completion of verbal direction; minimal participation in the routine, given physical intervention and verbal cues)

5. to actively assist in learning self help in skills (toileting, washing hands, dressing, etc.) (Child puts arms in coat when held; should be based upon CA expectations)

6. to respond with recall to the routine spontaneously (Child moves to next planned activity without physical stimulus; minimal verbal cues may be present)

7. to respond independently to play material (Age appropriate play not necessary)

Level 2 Behavior Goal - TO SUCCESSFULLY PARTICIPATE IN ROUTINES

8. to participate in playtime, mat time, games, music, art time, activities with appropriate body movements without physical intervention by teacher for an entire activity time (Verbal support may be used)

9. to participate in worktime, story time, talking time, juice and cookie time with uninterrupted sitting during required periods (without physical intervention by teacher; verbal support may be used)

10. to use play materials appropriately, simulating normal play experience

11. to wait for his turn without physical intervention by teachers; verbal support may be used

12. to spontaneously participate in routines without physical or verbal support

Level 3 Behavior Goal - TO APPLY INDIVIDUAL SKILLS IN GROUP PROCESSES

13. to contribute to making group rules of conduct and procedures

14. to verbally recall group rules and procedure

15. to verbalize consequences if group's rules are broken

16. to verbalize simple reasons for group's rules (verbal cues from teacher may be used)

17. to verbalize other ways to behave in a given situation; individual focus (may not be able to implement alternatives)

18. to refrain from inappropriate behavior or breaking group rules when others in group are losing control (given verbal support by teacher)

19. to maintain self-control and comply with group procedures (given classroom structure and verbal support by teacher)

Level 4 Behavior Goal - TO CONTRIBUTE INDIVIDUAL EFFORT TO GROUP SUCCESS

20. to implement alternative behavior toward others

21. to verbally relate behavior to situations or incidents

22. to respond appropriately to choices for leadership in the group (either not being selected or being selected leader) (Same as Socialization #26)

23. to spontaneously participate in activities previously avoided (without teacher structure) (Same as Socialization #27)

24. to respond to provocation with verbal and body control (with verbal support from teacher)

25. to respond to suggestions of a new experience (or change) with appropriate verbal and body control

Level 5 Behavior Goal - TO RESPOND TO CRITICAL LIFE EXPERIENCES WITH ADAPTIVE-CONSTRUCTIVE BEHAVIOR

26. to respond to a critical interpersonal or situational experience with constructive suggestions for change, as with constructive problem-solving behavior

FORM 18 (continued)

Communication

Level 1 Communication Goal - TO USE WORDS TO GAIN NEEDS

1. to attend to person speaking (Child looks directly at adult when adult initiates verbal stimulus, not necessarily eye contact)

2. to respond to verbal stimulus with a motor behavior (Following a command, child points to answer, or makes a choice)

3. to discriminatively respond to verbal stimulus with a recognizable approximation of the appropriate verbal response (Child gives correct answer to question, "What is this?")

4. to voluntarily initiate a recognizable verbal approximation to obtain a specific object, activity, person (Child produces recognizable approximation spontaneously)

5. to produce a recognizable word to obtain a desired response from adult

6. to produce a recognizable word to obtain a desired response from another child

7. to exhibit a beginning emergence of self (indicated by age approximate human figure drawing; use of personal pronoun I, me, my, or looking at self in mirror)

Level 2 Communication Goal - TO USE WORDS TO AFFECT OTHERS IN CONSTRUCTIVE WAYS

8. to produce a meaningful, recognizable sequence of words to obtain a desired response from adults or children in the classroom

9. to exhibit a receptive vocabulary no more than two years behind chronological age expectations (as indicated by the PPVT or other means)

10. to label feeling in pictures of peers or self: sad, happy, angry, afraid, (by gesture or word)

11. to answer a child's or adult's request with recognizable, meaningful words

12. to spontaneously use meaningful word sequences to direct an activity or request of another child and of an adult in ways acceptable to the classroom rules (Child uses word sequences to command and obtain requested results)

13. to use words spontaneously to exchange information with an adult

14. to use words spontaneously to exchange information with another child (Minimal verbal spontaneity with information content; requests or demands not applicable)

Level 3 Communication Goal - TO USE WORDS TO EXPRESS ONESELF IN THE GROUP

15. to use words to describe own activity, work, or self to another adult or child

16. to use words to praise own work, activity, or self

17. to accept praise or success without inappropriate behavior or loss of control

18. to use appropriate words or gestures to show feeling responses to environment, materials, people, animals

19. to contribute to making group rules of conduct and procedure (Same as Behavior #13)

20. to verbally recall group rules and procedure (Same as Behavior #14)

21. to verbalize consequences if group's rules are broken (Same as Behavior #15)

22. to verbalize simple reasons for group's rules (Verbal cues from teacher may be used) (Same as Behavior #16)

Level 4 Communication Goal - TO USE WORDS TO EXPRESS AWARENESS OF RELATIONSHIP BETWEEN FEELINGS AND BEHAVIOR IN SELF AND OTHERS

23. to verbally recognize feeling in others of sad, happy, angry, afraid

24. to recognize and acknowledge feelings in self of sad, happy, angry, afraid

25. to use words to praise or personally support others

26. to use words or gestures to express own feelings spontaneously and appropriately

27. to use words or gestures appropriately to express awareness of feelings in others (peers, adults)

28. to verbally express cause and effect relationship between feelings and behavior; between group members, and between individuals (group problem solving)

Level 5 Communication Goal - TO USE WORDS TO ESTABLISH AND ENRICH RELATIONSHIPS

29. to use words to initiate and maintain positive relationships: peer and adult

FORM 18 (continued)

Socialization

Level 1 Socialization Goal - TO TRUST AN ADULT SUFFICIENTLY TO RESPOND TO HIM

1. to be aware of adult (Child looks at adult when adult speaks directly to child or touches him)
2. to attend to adult's behavior (Child looks at adult when adult is not focussing on child directly)
3. to respond to adult when child's name is called (Child looks at adult)
4. to respond to adult's verbally initiated request to conform (Child follows adult's verbal direction with correct physical movement)
5. to respond to adult's verbal and nonverbal requests to come to him (Child moves next to adult and looks at him; and child accepts adult's touch)
6. to seek contact with adult spontaneously (Child moves next to adult and touches him)
7. to produce a recognizable word to obtain a desired response from adult (Same as Communication #5)
8. to produce a recognizable word to obtain a desired response from another child (Same as Communication #6)

Level 2 Socialization Goal - TO PARTICIPATE IN ACTIVITES WITH OTHERS

9. to engage independently in organized solitary play
10. to exhibit a beginning emergence of self (indicated by age approximate human figure drawing; use of personal pronoun, I, me, my or looking at self in mirror) (Same as Communication #7)
11. to produce a meaningful, recognizable sequence of words to obtain a desired response from adults or children in the classroom (Same as Communication #8)
12. to participate spontaneously in specific parallel activities with another child using similar materials but not interacting
13. to wait for his turn without physical intervention by teachers; verbal support may be used (Same as Behavior #11)

14. to participate in cooperative activities with another child during playtime, indoor or outdoor

15. to participate in cooperative activities with another child during organized class activities

16. to initiate minimal movement toward another child within the classroom routine

Level 3 Socialization Goal - TO FIND SATISFACTION IN GROUP ACTIVITIES

17. to participate in a verbally directed sharing activity (Child passes the cookies; shares the materials; gives toy to another, cooperates in group project)

18. to take turns without verbal reminders from teacher

19. to share materials, ideas, activities (minimal verbal reminders from teacher)

20. to suggest activities or preference for play materials to the teacher for group activity

21. to participate without inappropriate response in activity suggested by another child

22. to indicate developing friendship by preference for a particular child or children

23. to recognize and describe characteristics of others

Level 4 · Socialization Goal - TO PARTICIPATE SPONTANEOUSLY AND SUCCESSFULLY AS A GROUP MEMBER

24. to verbally indicate preferences among members of the group by differentiating personal characteristics

25. to suggest group activity directly to peer group without teacher structure

26. to respond appropriately to choices for leadership in the group (either not being selected or being selected leader)

27. to spontaneously participate in activities previously avoided (without teacher structure)

28. to physically or verbally assist another child in difficult situation; to come to support of another

29. to respond with constructive problem-solving behavior to group and/or individual situations

Level 5 Socialization Goal - TO INITIATE AND MAINTAIN EFFECTIVE PEER GROUP RELATIONSHIPS INDEPENDENTLY

30. to initiate and maintain effective interpersonal and group relationships

FORM 18 (continued)

Academic Skills

Level 1 Academic Goal - TO RESPOND TO THE ENVIRONMENT WITH PROCESSES OF CLASSIFICATION, DISCRIMINATION, BASIC RECEPTIVE LANGUAGE CONCEPTS, AND BODY COORDINATION

1. to be aware of sensations and to attend to environmental stimuli (through looking directly at object or person in situations using tactile, kinesthetic, visual, auditory, gustatory, and olfactory modalities) (Same as Behavior #1)

2. to attend to environmental stimuli (through continued looking at object, person, and sounds after initial stimulus-response has occurred; through sustained sitting in chair during required activity time) (Same as Behavior #2)

3. to respond with motor behavior to single environmental stimulus: object, person, sound (Child gives correct motor or verbal response to the command, "Give me _______." - no choices offered) (Same as Behavior #3)

4. to respond with motor and body responses to multiple environmental and verbal stimuli (through imitation "do this"; through completion of verbal direction; minimal participation in the routine, given physical intervention and verbal cues) (Same as Behavior #4)

5. to imitate familiar acts of adults

6. to respond with rudimentary sensori-motor skill to repetitive manipulative tasks (Child can stack blocks, string beads, etc.; masters Gesell's 24 month level)

7. to imitate words and action of adult (This is ____ (adult gives words and objects))

8. to respond by simple discrimination to concrete environmental stimuli (Child gives correct motor or verbal response to the command, "Give me _________," two objects presented)

9. to respond with classification to concrete environmental stimuli of similar objects with similar attributes (Child gives correct motor or verbal response to "Which ones are the same?"; two pairs of objects presented)

10. to respond with classification of similar objects with different attributes (Child matches geometric block to puzzle box opening or Binet Form Board)

11. to indicate short term memory for objects and people (Child identifies missing objects and missing members of group)

12. to indicate memory for the order of classroom activities by gesture, body movement, or words

13. to indicate memory for verbal and numerical expressions (Child repeats three digits; three word phrases)

14. to respond to color with the correct discrimination (Child responds correctly to the command, "Give me __________ (red, blue, yellow)" by picking out correct object from four choices)

15. to discriminatively respond to verbal stimulus with a recognizable approximation of the appropriate verbal response (Child gives correct answer to question, "What is this?") (Same as Communication #3)

16. to voluntarily initiate a recognizable verbal approximation to obtain a specific object, activity, person (Child produces recognizable approximation spontaneously) (Same as Communication #4)

17. to produce a recognizable word to obtain a desired response from adult (Same as Communication #5)

18. to perform eye-hand coordination activities (At the four year level, such as building a bridge from cubes, copying a circle, cross)

19. to perform body coordination activities (At the four year level, such as riding a tricycle, alternate feet going up stairs, and standing balanced on one foot)

Level 2 Academic Goal - TO PARTICIPATE IN CLASSROOM ROUTINES WITH LANGUAGE CONCEPTS OF SIMILARITIES AND DIFFERENCES, LABELS, USE, COLOR; NUMERICAL PROCESSES OF ORDERING AND CLASSIFYING; AND BODY COORDINATION

20. to recognize body parts (eye, hand, foot, nose, leg, arm, knee) (Any response appropriate; gesture, word, etc.)

21. to recognize body parts in pictures (hair, ear, eye, hand, foot, nose, leg, arm, knee) (Any response appropriate: gesture, word, etc.)

22. to recognize uses of objects, toys, etc.

23. to discriminate between up, down; under, over; big, little; tall, small; hot, cold; first, last; (Child is able to demonstrate or point given opposites in pictures)

24. to label colors (black, purple, pink, orange, green, brown) (Child is able to choose object if given the word; child is able to give approximation of word when presented with color)

25. to rote count to 10

26. to count with one-to-one correspondence to five

27. to count with one-to-one correspondence to ten

28. to recognize groups of objects to five (how many?)

29. to recognize groups of objects to ten

30. to recognize written labels (own name, chair, table, part of written schedules)

31. to recognize written names for color words (red, blue, yellow, green) (Child selects appropriate color given written word)

32. to perform eye-hand coordination activities (At the five year level, such as drawing a recognizable person with body, copies triangle, rectangle, prints a few letters from memory, traces cross, copies first name from model)

33. to perform body coordination activities (At the five year level, such as skips using alternate feet, walking board, rolling ball and receiving rolling ball)

Level 3 Academic Goal - TO PARTICIPATE IN THE GROUP WITH BASIC EXPRESSIVE LANGUAGE CONCEPTS; SYMBOLIC REPRESENTATION OF EXPERIENCES AND CONCEPTS; FUNCTIONAL SEMI-CONCRETE CONCEPTS OF CONSERVATION; AND BODY COORDINATION

34. to write numerals to represent groupings (1-10)

35. to do numerical operations of addition and subtraction, through ten

36. to use ordinal concepts verbally (first - fifth, last)

37. to write first and last name and part of date with model

38. to read basic primary vocabulary words spontaneously in sentences in group reading

39. to write basic words from memory and dictation

40. to participate in group activity for writing and telling experience story or working on murals with stories

41. to listen to story telling as a member of a group

42. to perform eye-hand coordination activities at the six year level (Such as drawing a person with arms, legs, clothes, etc., writing first name incompletely from memory, tying shoes)

43. to perform body coordination activities at the six year level (Such as throwing and catching a ball, recognizing right and left, walking backwards, clapping in rhythm)

Level 4 Academic Goal - TO SUCCESSFULLY USE SIGNS AND SYMBOLS IN FORMALIZED SCHOOL WORK AND IN GROUP EXPERIENCES

44. to express experiences and feelings through art media

45. to express experiences and feelings through music and rhythm media

46. to do numerical operations of addition and subtraction above 10

47. to read and write quantitative words for measurement of distance, time, money, fractions

48. to write full name, address, date, from memory

49. to read and write basic use vocabulary spontaneously in complete sentences

50. to write individual experience stories

51. to contribute to group projects requiring expressive skills

Level 5 Academic Goal - TO SUCCESSFULLY USE SIGNS AND SYMBOLS FOR FORMALIZED SCHOOL EXPERIENCES AND PERSONAL ENRICHMENT

52. to write for communication of information

53. to write of feelings and attitudes in prose or poetry

54. to read for pleasure and for personal information

55. to read to obtain information on the feelings and behaviors of others

FORM 19
REPRESENTATIVE OBJECTIVES RATING FORM (RORF)

Child's Name ____________________ Class ____________ Date ____________

(# = inappropriate behavior) Rater ______________________________

Behavior

____1. aware, attend
____2. attend after stim.
____3. respond mot.
____4. respond w/mot.
____5. assist/learn. self-help
____6. respond w/recall
____7. resp. indep./ play mat.

____8. partic. activities no interven.
____9. partic. activities sit.
____10. use play mat./ appro.
____11. wait turn/no interven.
____12. spon. partic.

____13. contri. to gp. rules
____14. vb. recall rules/ proc.
____15. vb. conseq./ brk. rules
____16. vb. reasons/rules
____17. vb. other ways beh./ indiv.
____18. refrain # when others #
____19. main. self-contr., comply

____20. implem. alter. beh.
____21. vb relate beh.
____22. resp. appro./ l'der choice
____23. spon. partic./ activ. prev. avoid
____24. resp. provocation/ control
____25. resp. sugges./ appro.

____26. resp. experience/ construc.

Communication

____1. attend/speaker
____2. resp/motor
____3. discrim. resp./ approx.
____4. init. approx./ to obtain obj.
____5. word/adult resp.
____6. word/child resp.
____7. exibit emerg. of self

____8. wrd. seq.
____9. recep. vocab.
____10. label feel/picture
____11. answer req.
____12. direct activ./ vbal.
____13. wrds. spon/infor. w/adult
____14. exchange info.

____15. describing
____16. praising own
____17. accept praise w/o #
____18. verb. appro./ show resp.
____19. B13
____20. B14
____21. B15
____22. verb. reasons/ gp. rules

____23. vb. recog. feel./ others
____24. vb. recog. feel./ self
____25. verb. praise
____26. expre. feel./ wds., ges.
____27. expr. aware feel./ others
____28. expr. cause and effect

____29. wds. for posit. rel.

Socialization

____1. aware/adult
____2. attend/adult beh.
____3. resp. to name/ adult
____4. resp. request conform/adult
____5. resp. request come/adult
____6. seek contact/ adult
____7. C5
____8. C6

____9. solit. play
____10. C7
____11. C8
____12. paral. play/ spon.
____13. B11
____14. partic. coop. act./child at play
____15. partic. coop. act./child at organ. class
____16. init. min. move./child, routine

____17. partic. dire. sharing
____18. turns w/o remi.
____19. share/min. rem.
____20. sug. act. or pref./teachers
____21. partic. w/o # act; sugges./ child
____22. pref./child
____23. recog. char. of others
____24. pref./diff. pers. char.
____25. suggest. act.
____26. resp. appro./ leadership
____27. B23
____28. assist. child
____29. resp. w/prob.-solv.;gp.or ind.
____30. init. & main/. interp.,gp rel

FORM 19
(Continued)

Academic Skills

___ 1. B1
___ 2. B2
___ 3. B3
___ 4. B4
___ 5. imit. acts/adult
___ 6. resp. w/rud. s-m

___ 7. imitate wds/acts of adult
___ 8. resp. by simple, discrim./ concrete
___ 9. resp. w/classif./ concrete, simil.w/simil.
___ 10. resp w/classif./ simil. obj. w/diff. attri.
___ 11. short-term mem./obj.; people
___ 12. mem. for order/class act.
___ 13. mem. for verb., numer.
___ 14. resp. to color

___ 15. C3
___ 16. C4
___ 17. C5
___ 18. eye-hand coord./4 year
___ 19. body-coord. act./4 year

___ 20. recog. body parts
___ 21. recog. body parts/pict.
___ 22. recog. use of obj.
___ 23. discrim. up-down, etc.
___ 24. discrim. mixed colors
___ 25. rote to 10
___ 26. count to 5/1 to 1
___ 27. count to 10/1 to 1
___ 28. recog. gps/to 5
___ 29. recog. gps/ to 10
___ 30. recog. writ. labels
___ 31. recog. writ. names/ color wds.
___ 32. eye-hand coord./5 year
___ 33. body coord./ 5 year

___ 34. write num for gpings./1-10
___ 35. num. oper, add & sub./-10
___ 36. verb. ord. concepts
___ 37. write name, date w/mod
___ 38. read prim. vocab./spon.
___ 39. write basic/mem. & dic.
___ 40. part. gp. act./writ., tell, mural
___ 41. list. story/as gp.
___ 42. eye-hand/6 year
___ 43. body coord./6 year

___ 44. expr. thru art
___ 45. expr. thru rhythm
___ 46. add., sub./above 10
___ 47. read, write quant. words
___ 48. write name, ad, date
___ 49. read., wr. sent. (basic)
___ 50. indiv. exper. story
___ 51. gp. proj./expres. skill

___ 52. write for commun.
___ 53. write of feel., attit.
___ 54. read/pleas. and info.
___ 55. read/info. feel. and beh. of others

PROGRESS NOTES

FORM 20
RORF SUMMARY FORM

RORF SUMMARY

Name: ______________________

^ = Mastery ✓ = Primary Focus

	Date	BEHAVIOR																																						
14th	( )																																							
13th	( )																																							
12th	( )																																							
11th	( )																																							
10th	( )																																							
9th	( )																																							
8th	( )																																							
7th	( )																																							
6th	( )																																							
5th	( )																																							
4th	( )																																							
3rd	( )																																							
2nd Mastery & Focus	( )																																							
1st Mastery & Focus	( )																																							
Objectives		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39

		COMMUNICATION																																						
14th	( )																																							
13th	( )																																							
12th	( )																																							
11th	( )																																							
10th	( )																																							
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6th	( )																																							
5th	( )																																							
4th	( )																																							
3rd	( )																																							
2nd Mastery & Focus	( )																																							
1st Mastery & Focus	( )																																							
Objectives		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39

FORM 20
(Continued)
Page 2

RORF SUMMARY NAME: ____________

										SOCIALIZATION																					
	Date																														
14th	( )																														
13th	( )																														
12th	( )																														
11th	( )																														
10th	( )																														
9th	( )																														
8th	( )																														
7th	( )																														
6th	( )																														
5th	( )																														
4th	( )																														
3rd	( )																														
2nd Mastery & Focus	( )																														
1st Mastery & Focus	( )	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Objectives																															

* = Mastery X = Primary Focus

FORM 20
(Continued)
Page 3

RORF SUMMARY

NAME: ________________

	Date	School Readiness																																	
14th	( )																																		
13th	( )																																		
12th	( )																																		
11th	( )																																		
10th	( )																																		
9th	( )																																		
8th	( )																																		
7th	( )																																		
6th	( )																																		
5th	( )																																		
4th	( )																																		
3rd	( )																																		
2nd Mastery & Focus	( )																																		
1st Mastery & Focus	( )																																		
Objectives		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34

14th	( )																												
13th	( )																												
12th	( )																												
11th	( )																												
10th	( )																												
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8th	( )																												
7th	( )																												
6th	( )																												
5th	( )																												
4th	( )																												
3rd	( )																												
2nd Mastery & Focus	( )																												
1st Mastery & Focus	( )																												
Objectives		35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62

* = Mastery X = Primary Focus

FORM 21
SHORT RORF SUMMARY FORM

SHORT RORF

CODE NUMBER____________________ NAME ____________________

	Percent's of Objectives Mastered				
	Level 1	Level 2	Level 3	Level 4	Level 5
Fall ___ Class Lev					
Behavior					
Communication					
Socialization					
Academic Skills					
Winter ___ Class Lev					
Behavior					
Communication					
Socialization					
Academic Skills					
Spring ___ Class Lev					
Behavior					
Communication					
Socialization					
Academic Skills					
Summer ___ Class Lev					
Behavior					
Communication					
Socialization					
Academic Skills					

FORM 22

January 2, 1972

Revision #1

DIRECTIONS

Systematic Who-to-Whom Analysis Notation*

(SWAN)

The SWAN is an observational instrument based on the representative objectives of Developmental Therapy (Mary M. Wood). A training program has been developed for use of this instrument and can be scheduled at Rutland Center upon request.

For further information on the SWAN, contact Dr. William W. Swan, Coordinator of Evaluation, Rutland Center.

---

* (C) 1971

FORM 22
(Continued)

Systematic Who-to-Whom Analysis Notation

1. OBSERVES: When a child looks at someone (who is not talking) or something in the classroom, category "O" is recorded.

   In response to child's name being called: When the child observes someone who has just spoken his name, category "ON" is recorded.

   While talking: When a child is looking at another person while that person is talking, category "OT" is recorded.

2. PHYSICAL CONTACT: When a child initiates physical contact such as tapping another on the shoulder, patting another on the back, placing an arm around the shoulder of another, holding hands with another, sitting in another's lap, or any similar physical contact, category "C" is recorded.

   Inappropriate: When a child hits, slaps, kicks, knocks, grabs pushes, or pinches another or some similar physical contact, category "C-" is recorded.

   Restraint: When a child must be physically restrained or physically moved by the teacher, category "--" is recorded in the teacher's who-to-whom column.

   Receives: When a child receives appropriate physical contact, category "CR" is recorded.

   Receives Inappropriate: When a child receives inappropriate contact, the category "CR-" is recorded.

3. FOLLOWS DIRECTIONS: When a child conforms (motor behavior) to instructions given by the teacher and when such conforming is not the result of being physically moved, (above, "Restraint"), category "F " is recorded.

   Does not follow directions: When a child does not follow directions to conform, category "F-" is recorded.

4. WORKS: When a child works on something during any structured, individual activity time such as "work time", "art time", "organized game time", looks at the story book during "story time", or eats and drinks during "snack time", category "W" is recorded.

   Works, but not appropriately sitting: When a child is doing work, but is not appropriately sitting, category "W-" is recorded.

SWAN (Continued)

5. VERBALIZES: When a child initiates talk with a peer, teacher, or group, or is engaged in conversation with a peer or teacher, or group, and such language is understandable, category "V" is recorded.

Inappropriate: When a child screams, yells, uses obscene language, or is generally boisterous, or any similar behavior, or when any verbalization is indicated to be inappropriate by the teacher, category "V-" is recorded.

Non-understandable verbalization: When a child verbalizes and such verbalization cannot be understood by the recorder and there are no teacher cues to indicate that such talk was understandable, (this includes humming when such humming is not inappropriate) category "VN" is recorded.

I-statements: When a child uses a first person singular pronoun, i.e. I, my, mine, or me, category "VI" is recorded.

Group-Rules: When a child verbalizes concerning group rules, category "VG" is recorded.

In response: When a child verbalizes in response to a stimulus, such as when the teacher asks the child a question, and such stimulus is noted by the observer, category "VR" is recorded.

6. PHYSICAL ACTIVITY: When a child walks from one part of the room to another, moves a chair, or any similar physical (motor) behavior, category "A" is recorded.

Inappropriate: When a child knocks over a chair, lies on the floor when he is supposed to be sitting at the table, throws an object in a classroom, or some similar behavior, category "A-" is recorded.

Parallel play: When a child plays in the same, or a parallel, activity as a peer simultaneously, and does not interact in any way with this peer, category "P+" is recorded.

Play: When a child is participating in an activity, or with materials, with another child or children, or by himself, and such play is not classified as parallel play, category "P" is recorded.

Responding activity: When a child nods his head or "hunches" his shoulders, or some similar physical activity, while another is talking to him or in response to a question from another, category "RA" is recorded.

FORM 22
(Continued)

PROTOCOL RULES

1. The who-to-whom format allows the observer to note whether a child's behavior is directed to the teacher, another child, the group-materials, or himself. If a child's behavior is directed toward himself, such as "N", it is recorded in his column. If it is directed to someone else, it is recorded in the appropriate column. If a child "receives" behavior from another (e.g., "CR-"), the appropriate symbols are recorded in the "another's" column.

2. If the observer is unsure of the correct who-to-whom column, he records the symbol in the "group-materials" column.

3. "Inappropriate" categories have priority over all other categories, i.e., they are recorded before any other categories.

4. Verbal behavior has priority over physical behavior if the physical behavior is appropriate.

5. "Follows Directions" is recorded for only one three-second interval. After that time, "Activity" or some other appropriate category indicating behavior necessary for the completion of the direction is recorded.

6. Category "O" is recorded in the who-to-whom format under the column of the child being observed when, and only when, the child is looking at himself in the mirror in an appropriate manner.

7. All minor categories, those listed under major categories, have priorities in the order listed. For example, "Inappropriate physical activity" is recorded before "Parallel play" or "Play" if two or more occur simultaneously.

FORM 23

SWAN OBSERVATION SHEET

CHILD'S NAME: ______________________ Date __________ OBSERVER: ____________

TIME: Work Play Snack Story Recreation Special Game Art Activity

	Teacher	Gp/Mat								
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										

O:____

ON·____

OT:____

C:____

C-____

--:____

CR:____

CR-____

F:____

F-·____

W:____

W-____

V·____

V-____

VN:____

VI:____

VG:____

VR:____

A:____

A-:____

P+:____

P:____

RA:____

N:____

/·____

//:______

COMMENTS:

FORM 24

SWAN SUMMARY SHEET

SWAN SUMMARY (1/4/72)
Activity:___________

	0%	25%	50%	75%	100%
1. Observes "O" (B1 S2,S7,A1,A2) B2					
In response to child's name being called "ON" (S3)					
While talking "OT" (C1,S1)					
2. Physical contact "C" (S6)					
Inappropriate "C-"					
Restraint "--"					
Receives "CR" (S1,S5)					
Receives inappropriate "CR-"					
3. Follows directions "F" (B3,B4,S4,A3, A4) C2					
Does not follow directions "F-"					
4. Works "W" (B9)					
Works but not sitting "W-"					
8. Removal from view self "/"					

	0%	25%	50%	75%	100%
5. Verbalizes "V" (C4,C5,C6,S7,S8, S11,A16,A17) C8					
Inappropriate "V-"					
Non-understandable "VN"					
"I" statements "VI" (C7,S10)					
Group rules "VG" (B12,B14,B15,B16, C19,C20,C21,C22)					
In response "VR" (C3,C11,A15)					
6. Physical Activity "A"					
Inappropriate "A-"					
Parallel Play "P+" (B7,B10,S12)					
Play "P" (S9, S14)					
Responding activity "RA"					
7. Non-directed physical activity "N"					
Removal from view teacher "//"					

FORM 25

SWAN Short Summary
(Cygnet)

Name: ____________________ Code: ______________ Class: ______________

Quarter: ______________ Dates: ____________________ to ______________

		WORK	SNACK		
% POS	1st 2 wks Average				
	Last 2 wks Average				
	Net Gain or Loss				
% NEG	1st 2 wks Average				
	Last 2 wks Average				
	Net Gain or Loss				
% NEU	1st 2 wks Average				
	Last 2 wks Average				
	Net Gain or Loss				
% PLE	1st 2 wks Average				
	Last 2 wks Average				
	Net Gain or Loss				

Positive Categories

OT
ON
C
F
W
V
VI
VG
VR
P+
P
RA

Negative Categories

C-
--
F-
W-
V-
A-
N
//

Neutral Categories

O
VN
A
/

Notes:

FORM 26

TERMINATION CARD

TERMINATION CARD

Name ____________________ Parents' Name ____________________

Address ____________________ County ____________________

School ____________________ ____________________

Referral Source ____________________ ____________________

Reason for termination (Include level of therapy) ____________________

____

____

Type of termination: ___Circumstantial ___Provisional ___Permanent

Parent notified Date: __________ Comment: ____________________

School notified Date: __________ Comment: ____________________

Referral Source notified Date: ________ Comment: ____________________

____

Coordinator of Psychoeducational
Services

FORM 27

SCHOOL OR AGENCY CONTACT CARD

IV-A ____
Non IV-A ____

CHILD'S NAME ______________________ DATE ________________

PARENT'S NAME ______________________ R. C. Contact ____________

1. Child's Status
   ____ Referred ____ Enrolled ____ Tracking ___ County Service
   ____ Preschool ____ School Age County & School System ____

2. Participant (s) ____________________ Position ____________
   ____________________ Position ____________
   ____________________ Position ____________
   ____________________ Position ____________

3. Principal Contacted? yes ___ no ___

Location of Contact: ___ At Agency ______________________
(named)

4. ___ At Rutland Center ___ At school ___ At home ___ Telephone

5. Type of participation (check all applicable categories):
   ____ Educ. Planning Conference ____ Psych. Assessment
   ____ Conference ____ Educ. Assessment
   ____ 10 Week Conference ____ Direct Service to Child
   ____ Observation ___ At RC ___ At school
   ____ Termination Conference

____ Cancelled by ______________ Date ________________
____ Didn't Show

(Reverse of card:)

Summary of Contact

Specific Objectives to be worked on at school

Recommendations

Next Proposed Appointment

Signed ____________________

FORM 28

GUIDELINES FOR USE OF SCHOOL OR AGENCY CONTACT CARD

Purpose

"School or Agency Contact" cards are to be used for recording EVERY contact made by Rutland Center personnel which involves a public or private school or agency, and a specific child or children. Contacts initiated by a school or agency are also to be recorded on this card. The purpose of the card is to provide quantitative and qualitative information regarding children served by Rutland Center. They should provide staff with meaningful information on past contacts concerning a given child and provide significant information for future contacts. The card is designed to include all types of service to children presently provided at Rutland Center.

Information contained on the card will be used for data compilation for reporting to the various funding agencies, as well as for a permanent record of services to each particular child. For these two purposes, it is absolutely essential that for every contact, the information be recorded, and the card given to the evaluation team.

Recording Information

Fill in the identifying information at the top of the card: Child's name, date, parent's name, and Rutland Center contact (your name). Also check whether the child is IV-A or not IV-A eligible.

A child or family is IV-A Eligible if any one of the following criteria are met:

1. He lives in Greene, Madison, Morgan, or Oglethorpe Counties.
2. He is a Model Cities Resident (See map in hall downstairs)
3. He is an OEO Area Resident (See map in hall downstairs)
4. He is a "Housing Authority" Area Resident (See map in hall downstairs)
5. The family has received in the past two years or currently receives welfare support.
6. The family income level is $8,100.00 or below.

If a child or family does not satisfy any of the above criteria, he is not IV-A Eligible.

This information can be recorded prior to the contact, at the time that the appointment is made.

Use the following guidelines to recording information for items one through five (1-5) on the front of the card and the spaces on the back of the card.

1. Child Status

Only one category should be checked among the four listed on the first line:

Referred: For children who have had an initial referral form filed through a school, parent, or agency, and have not yet been staffed. This includes all children who have a referral form filed at a county outpost, as well as children referred directly to Rutland Center and are awaiting staffing.

Enrolled: For children currently enrolled in treatment programs, classes , at Rutland Center or enrolled in classes conducted at a county outpost by Rutland Center personnel. Also included, as enrolled, are children accepted at staffing for future placement at Rutland Center or in classes at an outpost. In other words, every child accepted at Staffing is considered to be enrolled on the date which he was Staffed, not on the date he actually begins attending class. Contacts made regarding staffing recommendations or for Educational Planning Conferences (EPC) for children accepted for placement are considered to be service to an enrolled child.

Tracking: For children terminated from treatment at Rutland Center or an outpost, but receiving periodic school and/or agency follow-up services.

County Service: For children not referred to Rutland Center or a county outpost, not enrolled, or tracked, but who receive some services from Rutland Center or outpost personnel. Contacts with teachers or agencies regarding children who have been screened or staffed but not accepted for evaluation or placement fall into this category.

If a referral form has been received on a child he is considered Referred until a decision is made at screening or staffing. The child's status changes from referred to County Service if the child is not accepted at screening. If he is accepted at screening for evaluation his status remains as referred. A child's status also changes at the time of staffing, to enrolled if the child is accepted at staffing, or to county service if he is not accepted at staffing. Any contacts prior to initial referral, or made for the purpose of assessing problems or consulting with teachers of non-referred children fall into this category.

On the second line under child's status the following information should be recorded. Check whether the child was of preschool age, (2 to 5-11 years old) or school age (6 to 14 years old.).

On the same line, write the name of the county in which the child resided at the time of the contact.

2. Participants:

All participants, including parents, teachers, other Rutland Center personnel, or agency personnel, should be recorded. Participants names and positions should be complete and properly spelled. An individual just "sitting in" or "observing" should be recorded as a participant. If parents are participants or observers during a contact, it will be necessary also to fill out a "Parent Participation Card."

3. Principal Contacted

All principals should be made aware of school contacts with children attending their school. Every effort should be made to inform them of the purpose of any school contact or any pertinent aspect of service to children in their school. Do not check this item no, unless you are certain that circumstances do not warrant the principal's awareness of this contact.

4. Location of Contact

Indicate the location of the contact by checking, at agency, at Rutland Center, at school, at home, or telephone. If the contact was located at an agency write in the name of the agency on the line directly after _____ at Agency. Check only one category from among those listed.

5. Type of Participation:

It may be necessary to check more than one category listed in this section. Check categories carefully to specify as closely as possible what transpired during a contact. For instance, if a school visit was initiated, a specific child was observed in a group, and a conference was held with that child's teacher, both observation and conference were arranged with the same teacher but regarding two different children, one to be observed, and one as the subject for a conference, it would be necessary to complete two separate cards. Each type of participation is described below.

A. Educational Planning Conference

This conference includes all educational planning conferences (EPC'S) for children who have been staffed at Rutland Center or a county outpost. EPC's for children accepted for placement at Rutland Center should be recorded only on this card. It is not necessary to write a conference summary. EPC's for children not accepted, should be recorded on the card, plus a summary of the conference should be written, typed, and will be placed in the child's permanent folder. This summary should be acceptable for distribution to school personnel.

B. Conference

This category includes the majority for conferences held during the year with school or agency personnel, such as consultation with teachers. Check this category for conferences held to obtain Referral Form Checklists from teachers or other sources and record this on the back of the card and for treatment meetings at which school or agency personnel was present.

C. 10th Week Conference

This category is applicable to all end of quarter conferences held with school or agency personnel.

D. Observation

This includes instances during which you observe a child at his school or other location, and when someone from a school or other agency such as the Reading Clinic or DFCS observes a specific child at Rutland Center or at another location with you. If the observation was held at a location other than the child's school or Rutland Center, indicate this on the back of the card, under summary.

E. Termination Conference

Conferences held for the purpose of termination of treatment at Rutland Center or a county outpost are included in this category. Contacts made in order to gather information for terminations should not be recorded here. Record them under "Conference" and specify the purpose of the conference on the back of the card. It is especially important for termination conferences to be accurately recorded since this information is transferred to permanent termination cards and is an important part of our evaluation data and tracking program.

F. Psychological Assessment

Check this category when a psychological assessment conducted by Rutland Center or outpost staff was the major purpose or one purpose for the contact.

G. Educational Assessment

Check this category when educational assessment conducted by Rutland Center or outpost staff was a major purpose or one purpose for the contact.

H. Direct-Service to Children

All contacts which involved personal contact with a specific child other than educational or psychological assessments are direct service to children. Examples of this are crisis intervention or counseling with children. The child's status is not important here, the important factor being that some service was imparted directly to the child in a location usually away from Rutland Center.

I. Cancelled By

If for any reason an appointment is not held because one party did not show, it is important to pursue the contact further. Follow-up is important in transferring skills or exchanging information from the Center to the school or agency and in establishing working relationships. Keep working with and contacting persons if you are not completely satisfied with a conference or are experiencing a lack of cooperation from school or agency personnel. Every contact which was cancelled by someone or not held because of someone not attending should be pursued on the same day.

J. Did Not Show

Pursue cases of absences on the same day. Try and discover factors which are preventing cooperation and work them out quickly and satisfactorily so that the next contact will be successful.

If a contact does not show at the appointed time but appears later the same day consider the appointment kept.

Date

Fill in the space to indicate on what day the conference was cancelled or the participants "did not show."

On side #2 of the card, record proceedings of the contact. Under summary include major points covered or important impressions. If the conference was held for the purpose of filling out a referral, or RFCL, or an educational planning conference, information gathering or termination note this here.

If you find a teacher or person whom you are working with has some confidential information or if you gain impressions of a confidential nature, record these on a separate sheet to be placed in the child's permanent folder. No information which is unconfirmed rumor or would be damaging to a child, teacher, school or parent, or agency should be recorded on this card. An example of this would be information given to you by a teacher concerning a child's parents or home life, such as "he is bad in school because his father beats him at home."

Specific objectives should be agreed upon by both school or agency personnel and the Rutland Center contact person. These objectives should be realistic and simple enough so that both the teacher and child are able to succeed in reaching the objective. Probably not more than two objectives would be appropriate for a teacher to work on with a child in her class. Progress toward meeting these objectives could be discussed at the next appointment. Remember to make objectives specific and realistic, chances are that the classroom teacher will have little support in implementing objectives. Encourage her to call you at Rutland Center if more assistance is required or if problems arise.

Under recommendations list any other procedures which would be helpful to this particular child. Some examples would be: Schedule for a neurological with ____________; Send for report from ____________; or Contact ____________ regarding preschool program.

FORM 29

CLASSROOM TEACHER QUESTIONNAIRE

Description:

A six question, one sheet form composed of items designed to elicit pertinent information for Rutland Center program improvement from regular classroom teachers who teach children served at Rutland Center.

Directions:

Since rehabilitation of the disturbed child is a team effort, communication between the regular school teacher and our staff is essential. Further, in order to continually improve our services to the child, the school system, and you, we need your opinion concerning our present system of operation. Would you fill out the enclosed questionnaire and mail it to us? Please feel free to express your honest reactions, both positive, and negative.

After we have summarized the responses, we will share this information with you.

Thank you for your assistance in helping us improve our services and effectiveness. (Enclose a self-addressed, stamped envelope for returns)

Use:

Program improvement based on the pertinent responses obtained from regular classroom teachers. The responses are listed for each question and are summarized into three groups: positive, neutral, and negative. The results are then reported to the administrative staff for possible program changes.

FORM 29
(Continued)

CLASSROOM TEACHER QUESTIONNAIRE*

Rutland Center
698 North Pope Street
Athens, Georgia 30601

1. Have you noticed behavior changes in children from your class participating in the Rutland Center Program? (Cite instances, if possibl

2. How many educational planning conferences at Rutland Center have you been able to attend this school year?
    a) Have these been helpful?
    b) If yes, why?
    c) If no, why not?

3. Is the transportation schedule satisfactory? (If no, please suggest changes)

4. How many times have you been able to observe your pupils at Rutland Center this year?

    Is there anything Rutland Center can do to facilitate your observation of pupils?

5. Is communication between you and Rutland Center adequate? If not, would you suggest which of the following be increased: conferences, letters, school visits, etc.

6. How many visits have you had from Rutland Center Staff?

7. We would appreciate any other comments, suggestions, questions, etc. (Use back of Questionnaire)

*Please return before last day of school.

FORM 30

PRINCIPAL QUESTIONNAIRE

Description:

A one-page form composed of nine questions, for obtaining pertinent information from principals who have pupils and/or teachers receiving some service from Rutland Center.

Directions:

Since rehabilitation of the disturbed child is a team effort, communication between the principal and our staff is essential. Further, in order to continually improve services to the child, to the school system, and to you, we need your opinion concerning our present system of operation. Would you fill out the enclosed questionnaire and mail it to us? Please feel free to express your honest reactions, both positive and negative.

After we have summarized the responses, we will share this information with you.

Thank you for your assistance in helping us improve our services and effectiveness. (Enclose stamped, self-addressed envelope for returns)

Use:

To obtain information and attitudes from the principal to enhance our services to school and child. The responses are listed for each question and summarized in three groups: positive, neutral, and negative, and are then reported to the administrative staff for possible program changes.

FORM 30
(Continued)

PRINCIPAL QUESTIONNAIRE*

Rutland Center
698 North Pope Street
Athens, Georgia 30601

1. Are you satisfied with current arrangements between your school and Rutland Center?

2. What could be improved?

3. Could you use observation or training workshops sponsored by Rutland Center for teaching techniques of working with E.D. children, either at the Center or in your school, and would you participate in the planning for such workshops?

4. Would you like more information about Rutland Center and its objectives in dealing with emotionally disturbed children?

5. How many Rutland Center educational planning conferences have you been able to attend this year?

6. Would you like to observe children from your school at Rutland Center?

7. Have there been any particular behavior changes in the children participating in the Rutland Center program? (Cite instances, if possible)

8. Do you think Rutland Center is the appropriate agency to meet these children's needs? (Please cite exceptions)

9. Other comments, questions, suggestions, etc. (Use back of Questionnaire

Principal__________________________
School____________________________

* Please return before last day of school.

FORM 31

SAMPLE FORM LETTER FOR TEACHER AND PRINCIPAL QUESTIONNAIRES

RUTLAND CENTER
685 & 698 North Pope St.
Athens, Georgia 30601

TO: Teachers and Principals Who Have Worked With Rutland Center Staff During 1971-72

FROM: Mary M. Wood, Director

Rehabilitation of a disturbed child requires effort and communication between his regular school teacher and principal and our staff. In order to improve our services to children, to the school system, and to you, we need your opinion concerning our present system of operation.

Would you fill out the enclosed questionnaire and mail it to us? Please feel free to express your honest reactions, both positive and negative.

Thank you for your assistance.

FORM 32

PARENT PARTICIPATION CARD

PARENT PARTICIPATION RECORD

IV-A
NON IV-A

CHILD'S NAME____________________ PARENT'S NAME____________________

DATE__________ TIME SPENT______________ SW/MONITOR_______________

SCHOOL SYSTEM____________________ COUNTY_____________ GRADE________

TYPE OF PARTICIPATION: (Circle One)

- Intake
- PPC
- 10th wk. conf (EOQ)
- Conference
- OBS
- Home
- Classroom Training
- Termination Conf.
- Parents Auxiliary Meeting

DID NOT SHOW

CANCELLED

TELEPHONE CONV.

CONTENT OF CONTACT:

S-1	P-1	O-1	H-1
S-2	P-2	O-2	H-2
S-3	P-3	O-3	H-3
S-4	P-4	O-4	H-4
S-5	P-5		
S-6	P-6		
S-7			

OTHER:__________________________

OBJECTIVES FOR HOME USE: Yes/No
(See Parent's Activities Card)

SUMMARY (See Back)

This contact was requested by:
(circle one) Parent Staff

(Reverse Side)

SUMMARY:____

FORM 33

CODING FOR PARENT PARTICIPATION CARD

I. Parent Conferences: to exchange information about referred child, on a weekly appointment basis.

Information given to Parent by Monitor and/or Lead Teacher:

S-1	Information about Rutland Center program and procedures.
S-2	Information concerning testing and diagnostic summary, recommendations (RFCL; RORF).
S-3	Information concerning child's progress at Rutland Center (RORF Summary)
S-4	Information on general child management techniques and discipline at home.
S-5	Information of Rutland Center management techniques.
S-6	Information on work with child by center staff at the school.
S-7	Information on other community resources to help parent or child.

Information given to Monitor by Parent:

P-1	Information on child's past history (medical, home, school, other agency, etc.)
P-2	Information on current behavior of child at home, neighborhood, school, other agency.
P-3	Information on techniques of management of child used at home.
P-4	Information on current problems at home.
P-5	Information on past and current relationships at home.
P-6	Information concerning relationship and activities of members of the family in the neighborhood and community, past and present.

Figure 1 continued

II. Observation: Learning about the center program for the referred child by observing the class through the two-way mirror.

O-1 To see child's progress and developing skills in relation to current major treatment objectives.
O-2 To see and discuss current problem areas center and child may be working through.
O-3 To see demonstration of management techniques used by center staff with child.
O-4 To see and discuss how to use particular techniques which could be conducted at home.

III. Home Program: Parents and staff member, working in center or home, specifically on objectives and activities parents will use at home.

H-1 To assist staff in becoming familiar with child's behavior at home.
H-2 To assist staff in becoming familiar with parents' techniques for management of child at home.
H-3 To plan with parents ways child can be managed at home more comfortably.
H-4 To plan with parent ways to implement objectives at home.

IV. The Parent Training Program: Parent working as a part of a treatment team in a classroom as the support teacher on a volunteer basis.

FORM 34

PARENT ACTIVITY CARD

CHILD'S NAME ____________________ PARENT'S NAME ____________________

QUARTER ________________ DATE ________ MONITOR ____________________

OBJECTIVE NO.

____

____

____

____

____

(Reverse Side)

PARENT RATING FOR EFFECTIVENESS

Activity	(circle one) highly	 moderately	 slightly

FORM 35

July, 1972

GEORGIA PSYCHOEDUCATIONAL CENTER NETWORK

____________ Monthly Summary for Children

__________197__ to ________, 197__

	Pre		School		Total	
	IV-A	Non-IV-A	IV-A	Non-IV-A	IV-A	Non-IV-A
1. Total No. Children Receiving Services (Center and County)						
2. Total No. Children Referred						
a. No. Screened and Referred to Other Sources						
b. No. Screened with Action Pending (further info., etc.)						
c. No. Accepted for Intake						
d. No. To Be Handled in School with Center Help (Outpost)						
e. No. Children with Parent Services Only						
f. No. with Other Services						
g. No. Dropped from Referral List for Other Reasons						
3. No. Accepted for Intake Prior to First of Month, but Not Staffed by Last of Month						
4. Total Children in Intake						
5. Total No. Receiving Testing and Assessment						
a. No. Receiving Educationals						
b. No. Receiving Psychologicals						
c. No. Receiving Psychiatrics						
d. No. Infant Assessments (below age 3)						
6. Total No. Children Staffed						
a. No. Restaffed						
b. No. Accepted (on waiting list)						
c. No. Accepted (enrolled this month)						
d. No. Referred to Other Sources						
e. No. Handled in School with Center Help						
f. No. with Only Parent Work						
g. Other						
7. Total No. Children in Therapeutic Classes at Center						
8. Total No. of Terminations from Services						
a. Circumstantial (withdrawn)						
b. Provisional (improved)						
c. Final						
9. TOTAL in Tracking						
10. Total No. Children Receiving Medical and/or Dental Care						

(Over)

FORM 35
(Continued)

Totals By School Systems and Counties

11. School Systems and County	No. Referred to Center	No. Tested	No. Served At Center	No. Served in County/School System

FORM 36
EXPLANATION OF MONTHLY SUMMARY REPORTS
GEORGIA PSYCHOEDUCATIONAL CENTER NETWORK
Center Monthly Summary for Children

1. Total No. Children Receiving Services: Number of children receiving any kind of services either at the Center or at one of the outposts.

2. Total No. Children Referred: Number of children referred to a center or an outpost.
   a.
   b.
   c. These relate to the referral disposition and should
   d. account in total for the total number of referrals.
   e. A number for each would be entered in the appropriate
   f. space in the Monthly Summary.
   g.

3. No. Accepted for Intake Prior to First of Month, but not Staffed by last of Month: Number of children, so involved in the Intake.

4. Total Children in Intake: Number of children who have been accepted for Intake but have not been Staffed.

5. Total Number Receiving Testing and Preliminary Evaluation: Number of children who have received some testing or preliminary evaluation, either in the center or at an outpost.
   a.
   b. Number of children receiving these types of
   c. testings. Enter the number in the appropriate
   d. space.

6. Total Number of Children Staffed: Total number of children staffed.
   a.
   b.
   c. These indicate the staffing disposition.
   d. Enter the number in the appropriate spaces.
   e.
   f.
   g.

7. Total Number of Children in Therapeutic Classes at Center or Outpost: This is the number of children attending therapeutic classes.

8. Total Number of Terminations: Number of children who have been terminated from therapeutic classes.
   a.
   b. Number of children appropriately entered for each
   c. type of termination.

9. Total in Tracking: Number of children terminated and receiving followup services.

FORM 36
(Continued)

10. Total Number of Children Receiving Medical and/ or Dental Services: Number of children receiving such services.

11. Totals by School Systems and Counties: Number receiving services as indicated by county and/or school system.

Center Monthly Summary of Parent Services

1-11 Types of services which parents can receive and participate in. Definitions for each of the types of activities or services are listed in the prototype grant or are accepted definitions of the professional fields.

Entries should be by county and by school system and should be the number of hours in each of the particular service areas. Any center might not offer all services. For those services not offered, please enter zeroes.

Total Number of Hours of Contacts and Total Number of Families Served by County and School Systems are self explanatory.

FORM 37

GEORGIA PSYCHOEDUCATIONAL CENTER NETWORK
__________Monthly Summary of Parent Services
__________, 197_ to __________, 197_

* **Entries** 1-11 are
hours of contacts

	Counties and School Systems																Totals	
																	IV-A	Non Iv-A
1. Initial Referral and Intake Services																		
2. Parent Planning Conferences																		
3. Conferences																		
4. Counseling																		
5. Conferences-Counseling																		
6. Home Program																		
7. Observation																		
Training																		
9. Crisis Intervention																		
10. Family Followthrough																		
11. Other (Specify on Reverse Side)																		
Total Cancellations and Do Not Shows																		
Total Hours of Contacts																		
Total No. of Families Served																		

(Continue on back if necessary)

FORM 38

GEORGIA PSYCHOEDUCATIONAL CENTER NETWORK
DEMOGRAPHIC DATA CODING

Description:

This set of forms is composed of (1) a Demographic Data Card Format, (2) a two-page form indicating specific codes for particular demographic data, (3) a socioeconomic index from Methodology and Scores of Socioeconomic Status, Bureau of the Census, Working Paper #15, 1960, and (4) a sample of the Demographic Data Coding Layout Sheet.

Directions:

This information allows one to record specific demographic descriptors for each child referred to the center who receives some sort of assessment at the center. This includes all children who attend classes at the center. The user takes information from various intake forms, particularly the Initial Intake Information, and codes the particular data as specified in the forms listed above.

Use:

These data are used for describing the children attending a center and are used to tentatively plan for types of children served in the future. Additionally, a center can specify the types of children currently served and possibly alter the program to meet particular needs of groups of children not being served. These data are useful also to other professionals in the area who are concerned with particular groups of children being served by the Network.

FORM 38
(Continued)

THE GEORGIA PSYCHOEDUCATIONAL CENTER NETWORK

DEMOGRAPHIC DATA CARD FORMAT

Columns	Information
1-5	Child's I.D. Number
6-7	Center Number
8-9	County Number
10	Sex
11	Race
12-17	Initial Referral Date (mo., yr.)
18-23	Date of Birth (mo., day, yr.)
24-25	Grade in School on Initial Referral
26	Referral Source
27-30	Screening Date (mo., yr.)
35	Referral Disposition
36-39	Date of Initial Intake (mo., yr.)
40	Previous Treatment
41	Parents' Marital Status
45-46	Parents' Education Score
47-49	Family Income Score
50-51	School System #
52-53	Sibling Number
54-55	Sibling Position
56-59	Staffing Date (mo., yr.)
60-61	Staffing Disposition
62-65	EPC (mo., yr.)
66-69	PPC (mo., yr.)
70	Age Group
71-72	Card #
73	IV-A Eligibility

FORM 38
(Continued)

DEMOGRAPHIC DATA CODING

I. Center Numbers

1 - Athens
2 - Brunswick
3 - Savannah
4 - Thomasville
5 - Valdosta
6 - Carrollton
7 - Waycross
8 - Milledgeville
9 - Dalton
10 - Gainesville
11 - Dublin
12 - Americus
13 - Waynesboro

II. County of Residence (Determined by Individual Center)

0 - Clarke
1 - Other than those served
2 - Madison
3 - Morgan
4 - Oconee
5 - Oglethorpe
6 - Greene

III. Sex

1 - Male
2 - Female

IV. Race

1 - White
2 - Black
3 - Other

V. Grade Placement at Referral

0 - Preschool
1 - Kindergarten
2 - 1st Grade
3 - 2nd Grade
4 - 3rd Grade, etc.
14 - EMR
15 - Special Ed. Class

VI. Referral Sources

1 - School
2 - Parent or Legal Guardian
3 - Physician
4 - Speech and Hearing Clinic
5 - Welfare (DFCS)
6 - Court
7 - Other agency or professional
8 - Other

VII. Referral Disposition (Use Analogous Agencies)

0 - Intake
1 - Ga. Retardation Center
2 - Comp. Comm. Mental Health Center
3 - Family Counseling Service
4 - D.F.C.S.
5 - Dr. Richmond
6 - Speech and Hearing Clinic
7 - Work with child and/or teacher in school
8 - University Reading Clinic
9 - Other

VIII. Previous Treatment

0 - None
1 - Private Psychiatrist
2 - Psychology Clinic
3 - Speech and Hearing Clinic
4 - Rutland Center
5 - Other
6 - Speech therapy or special reading at school

IX. Parent Marital Status

0 - Married
1 - Divorced
2 - Separated
3 - Foster
4 - Widowed
5 - Remarried
6 - Legal Guardian
7 - Adoptive Parents
8 - Other
9 - Single

X. School System (Determined by Individual Center)

FORM 38
(Continued)

XI. Staffing Disposition

10 - Into program (group)
11 - Into program (individual therapy)
20 - Private Treatment
31 - EMR
32 - TMR
33 - No Treatment Indicated
34 - Learning Disabilities
35 - Work with Crisis Teacher
36 - Regular Preschool Program
37 - Regular School Program
38 - Crippled Children's Service
39 - Speech and Hearing Clinic
40 - Head Start
41 - Waiting List
42 - Work with Parents Only
43 - Other

XII. Age Group ==

1 - Infant Birth - 2-11
2 - Preschool 3-0 - 5-11
3 - School Age 6-0 - 14-0

XIII. IV-A Eligibility

0 - Not Eligible
1 - County
2 - Model Cities Resident
3 - OEO Area Resident
4 - Welfare Recipient
5 - Housing Authority Resident
6 - Income Level

FORM 38
(Continued)
A SOCIO ECONOMIC INDEX

From: Methodology and Scores of Socioeconomic Status
Bureau of the Census; Working Paper #15, 1960

Scores for Categories of Major Occupation Groups

Score	Category	Score	Category
90	Professional, technical, & kindred workers	45	Operatives & kindred workers
81	Managers, officials, & proprietors, except farm	34	Service workers, including private household
71	Clerical, sales, & kindred workers	20	Laborers, except farm & mine
58	Craftsmen, foremen, & kindred workers		

Scores for Categories of Years of School Completed

Score	Category	Score	Category	Score	Category
98	College: 5 or more	67	High School: 4	23	Elementary: 8
93	4	49	3	13	7
89	3	42	2	08	5 & 6
86	2	34	1	04	3 & 4
83	1			02	1 & 2
				01	None

Scores for Categories of Family Income (or Income of Persons Not in Families)

Score	Category	Score	Category	Score	Category
100	$25,000 or more	74	$7,000 to $7,499	21	$3,000 to $3,499
98	$15,000 to $24,999	69	$6,500 to $6,999	17	$2,500 to $2,999
94	$10,000 to $14,999	63	$6,000 to $6,499	12	$2,000 to $2,499
89	$9,500 to $9,999	57	$5,500 to $5,999	08	$1,500 to $1,999
87	$9,000 to $9,499	49	$5,000 to $5,499	05	$1,000 to $1,499
84	$8,500 to $8,999	41	$4,500 to $4,999	03	$500 to $999
81	$8,000 to $8,499	34	$4,000 to $4,499	01	Loss, none, or less than $500
78	$7,500 to $7,999	27	$3,500 to $3,999		

FORM 38
(Continued)

FORM
SAMPLE DEMOGRAPHIC DATA CODING SHEET

Line No.	Child's I.D. Number					Center #		County #		Sex	Race	Initial Referral Date						Date of Birth						Grade in School on initial referral		Referral Source	Screening Date				Re-screening Date				Referral Disposition	Date of Initial Intake				Pre-Treat.
												M	o	Day		Year		M	o	Day		Year					M	o	Year		M	o	Year			M	o	Year		
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
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FORM 38
(Continued)

Marital Status				Parent's Education Score		Family Income Score					Sibling Number		Sibling Position		Staffing Date				Staffing Disposition		EPC				PPC				Age Group	Card #		IV-A Eligibility								Line No.
															Mo		Year				Mo		Year		Mo		Year													
1	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	
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